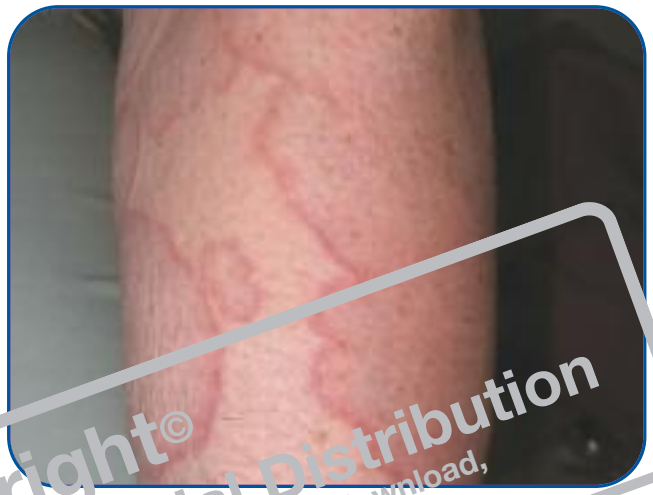
Large, Red, Annular Plaques

Benjamin Barankin, MD, FRCPC

Meet Shawna

- Shawna is a 42-year-old cashier with a four-year history of large, annular, erythematous plaques with slightly raised borders on her arms, chest, and thighs. There is occasional pruritus.
- She has a history of hypothyroidism and mild hypertension, She is on no medications.
- She's tried various topical cortisone and antifungal creams, but nothing seems to work.



What is your diagnosis?

a) Tinea corporis
b) Granuloma annulare
c) Discoid lupus erythematosus
d) Nummular dermatitis
e) Psoriasis

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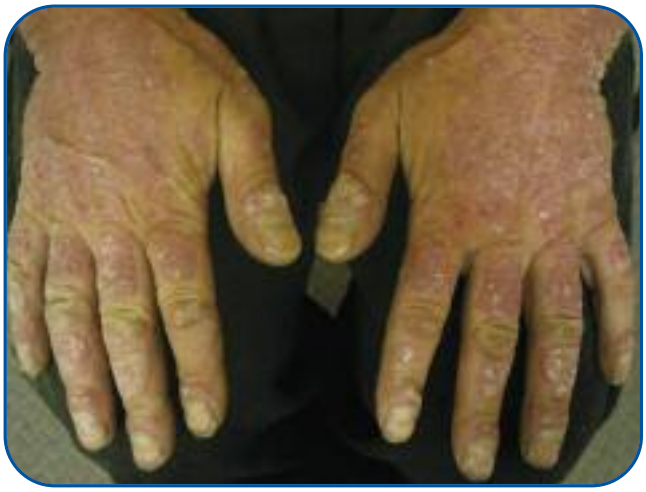
See page 2 for the answer to last month's case

Here is the answer to last month's case

Meet Joseph

- Joseph is a 46-year-old pharmacist with a two-year history of erythematous and scaly plaques on his dorsal hands
- He's tried various cortisone creams but nothing seems to work
- Steve finds that his condition is interfering with his work and hobbies
- Even his social life has suffered, because he's embarrassed to shake hands with people
- He is currently taking lithium for bipolar disorder and has no drug allergies or family history of skin problems



What is your diagnosis?

a) Atopic dermatitis
b) Allergic contact dermatitis
c) Irritant contact dermatitis
d) Psoriasis
e) Dermatomyositis

Answer: D

Psoriasis **(answer d)** is a common (~2% in North America), chronic, recurrent, noncontagious, inflammatory skin disorder of unknown etiology and genetic basis. Clinically, plaque psoriasis (the most common type) manifests as well-circumscribed, elevated, salmon-coloured plaques with dry, silvery-white scales that vary in size between one and several centimeters. There can be anywhere from few to many at any given time. The plaques are located symmetrically on extensor surfaces (elbows & knees), the scalp, and the trunk. Often the nails are involved with pitting, "oil drop" sign, onycholysis, and subungual thickening. While the skin is the primary organ affected, joints may be affected in 10 to 30% of cases (oligoarthritis in 70%).

The three treatment modality classes are topical agents, phototherapy, and systemic agents; they can be used alone or in combination.

Topical therapy is the first-line approach in the treatment of plaque psoriasis in those with less than 10% of their body surface being affected, and it most commonly includes topical steroids and Vitamin D analogues, such as calcipotriene and calcitriol. Intralesional triamcinolone can be injected into isolated or stubborn plaques.

Phototherapy is used in the presence of extensive, widespread disease (> 10%), in those that have become resistant to topical treatment, or in combination with topical therapy. Proper facilities and time commitment (two to three visits/week) are required for both UVA and UVB phototherapy.

Systemic therapy is needed in the presence of psoriatic arthritis, as well as in those who have a disease that is physically, psychologically, socially, or economically disabling. All patients must be informed of the risks and adverse effects of systemic therapy before treatment is initiated. Methotrexate and acitretin have been considered the gold standards of systemic therapy for many years.

Biologic medications, such as adalimumab, alefacept, etanercept, infliximab, and ustekinumab are agents now commonly used in those not tolerating traditional systemic agents, or in those with contraindications to traditional systemics, and/or in those with psoriatic arthritis.

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Congratulations
to our winner for the month of May 2011!
Dr. Jasper Burger
Delta, British Columbia