Francine's Firm Plaque

Benjamin Barankin, MD, FRCPC

Meet Francine

- Francine is a 34-year-old Asian female with a several month history of a slowly enlarging firm plaque on her back
- The lesion is occasionally pruritic and feels dry and wrinkly to the touch
- Francine has no personal or family history of skin problems
- Francine has hypothyroidism for which she is on medication and is otherwise healthy with no drug allergies

What is your diagnosis?

a) Sclerodema
b) Sclerotic basal cell carcinoma
c) Morphea
d) Lipodermatosclerosis
e) Stiff skin syndrome

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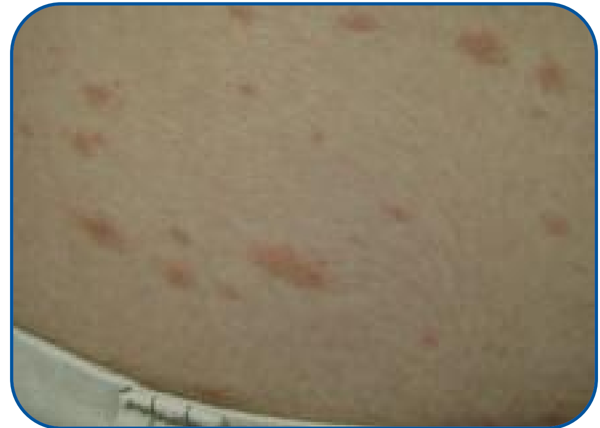
See page 2 for the answer to last month's case

Here is the answer to last month's case

Meet Randy



- Randy is a 34-year-old male with a rash that appears to have been spreading over the past few weeks. It is associated with some mild pruritus
- He originally noted a round, scaly, red spot on his abdomen and, a few days later, many more smaller rashy spots showed up on his abdomen and back, with only a few on his arms and legs and none on the face, palms, or soles

What is your diagnosis?

a) Syphilis
b) Pityriasis rosea
c) Nummular dermatitis
d) Lichen planus
e) Tinea corporis

Answer: B

Pityriasis rosea (PR) is a benign, common skin disorder observed in otherwise healthy children and young adults. It presents as an acute, self-limiting, papulosquamous eruption with an average of six to eight weeks duration (and up to three to six months). Lesions are salmon-coloured and slightly scaly. This is an idiopathic condition; although, the strongest suggestion is for an infectious etiology. Most recently, there has been interest in the human herpes viruses, namely HHV-6 and HHV-7, but the evidence is inconclusive.

History reveals a small number of patients with prodromal symptoms, such as fatigue, nausea, or arthralgias. Patients may note a recent upper respiratory infection and lymphadenopathy. If carefully questioned, patients often (75%) note a preceding herald patch (large, scaly plaque on trunk, 2 to 10 cm), with subsequent development of a diffuse, finely scaled rash one to four weeks later. The rash is generalized on the trunk and often runs parallel to Langer's skin lines, resulting in a "Christmas tree" pattern. Oral lesions are quite uncommon. Mild to moderate pruritus in PR is relatively common in the first few weeks of the rash.

Atypical variants of PR (up to 20%) make this condition difficult to diagnose. Some morphologies that have been reported include: erythema multiforme–like, purpuric, pustular, urticarial, and vesicular. The differential diagnosis includes: guttate psoriasis, nummular eczema, drug eruptions, seborrheic dermatitis, tinea versicolor, pityriasis lichenoides, viral exanthems, tinea corporis, and syphilis.

The diagnosis of PR is clinical, and laboratory tests are rarely indicated. If only a herald patch is evident, a potassium hydroxide (KOH) test searching for tinea corporis is reasonable. If the palms or soles are involved in a sexually active individual, testing for secondary syphilis is warranted (*e.g.*, VDRL). Atypical presentations of PR or persistent rashes can be biopsied, but biopsy will only reveal non-specific features of dermatitis; its role is predominentl to rule out other conditions.

Management of PR involves education and reassurance as this is a self-limited condition with minimal sequelae other than some temporary post-inflammatory hyperpigmentation. Patients do not require isolation or any change in their activities. Patients with pruritus will benefit from symptomatic relief with calamine, menthol, pramoxine, or oatmeal-containing products. Interestingly, oral antibiotics (*e.g.*, erythromycin) or oral antivirals (*e.g.*, acyclovir) instituted soon after development of the rash may hasten its resolution.

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Congratulations
to our winner for the months of July/August 2011!
Dr. Jim Cross
Christopher Lake, Saskatchewan