This month — 7 cases:

Case 1

Multiple Dots on the Face

This 60-year-old man is concerned about an increasing number of dots appearing in the lateral orbital area bilaterally.

What is your diagnosis?

a. Sun freckles
b. Lentigines
c. Favre-Racouchot syndrome
d. Poikiloderma of civatte
e. Cutis rhomboidalis nuchae

Answer

He has Favre-Racouchot syndrome **(answer c)**. There are multiple skin conditions that are caused by sun damage that appear gradually over the years and are not precancerous. These include sun freckles, lentigines, Poikiloderma of civatte at the sides of the neck, rhomboidalis nuchae, as well as Favre-Racouchot syndrome. This entity consists of multiple, large, open comedones on the lateral and inferiour aspects of the orbital area.

It most commonly occurs in older individuals with associated solar elastosis.

Individual comedones can be expressed, and topical retinoids can be applied to these areas to slow the inevitable recurrence of comedones. Sun protection is also advised.

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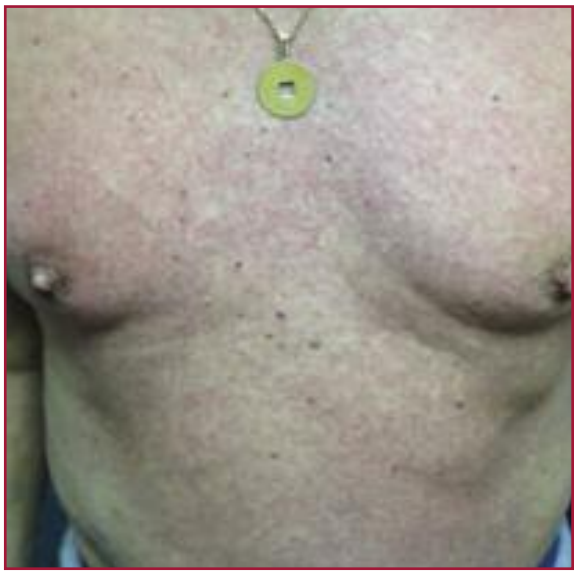
Case 2

Itchy Chest Rash



Mr. PW is a 55-year-old gentleman presents to the office for an emergency appointment, as he is very concerned about his generalized, itchy skin rash. It started the day before and is worsening.

He was discharged from hospital five days prior, after he was successfully treated with suprapubic catheterization for his complete urethral injury, which he sustained after a straddle injury at work.

He was started on trimethoprim/sulfamethoxazole as prophylaxis against infection.

He is usually fit and well and is not aware of any drug allergies; he takes venlafaxine 37.5 mg a day for his mild depression.

He has not been abroad recently, and he does not recall being in contact with any person who was in ill health as of late.

What is your diagnosis?

a. Exanthematous drug eruption
b. Mononucleosis
c. Measles
d. HIV infection

Answer

An exanthematous drug eruption **(answer a)** is an adverse hypersensitivity reaction to an ingested or parenterally-administrated drug, characterized by a cutaneous eruption that mimics measle-like viral exanthema; systemic involvement is low.

Drugs with a high probability of reaction (3 to 5%) are:

- Penicillin and related antibiotics
- Carbamazepine
- Allopurinol
- Gold salts (10 to 20%)

Medium probability: 1-2%:

- Sulphonamides
- Non-steroidal anti-inflammatory drugs
- Hydantoin derivative
- Isoniazid
- Chloramphenicol
- Erythromycin

Low probability (less than 1%):

- Barbiturates
- Benzodiazepines
- Tetracyclines

The definitive step in management is to identify the offending drug and discontinue it.

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

Spider-like Cheek Lesion

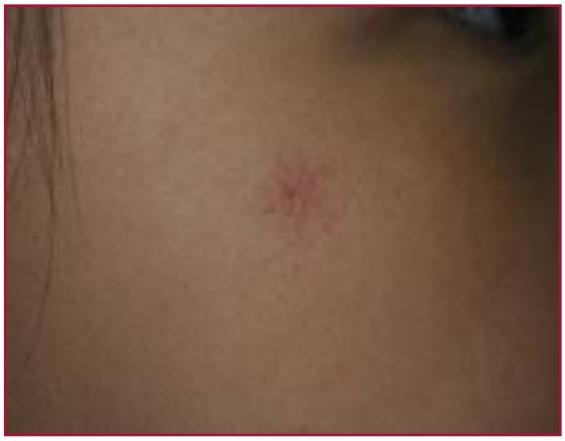
A seven-year-old girl is noted to have a spider-like lesion on her right cheek. The child is asymptomatic and healthy.

What is your diagnosis?

a. Rosacea
b. Spider angioma
c. Salmon patch
d. Erythema ab igne

Answer

A spider angioma **(answer b)** is a type of telangiectasia that is characterized by a dilated, central-feeding arteriole and numerous small, radiating branches that together resemble a spider's body and legs. The site of predilection is the cheek. The lesion blanches when pressure is applied to the central arteriole. It quickly refills once the pressure is released. Pulsations may be visible in larger lesions. Spider angiomas are seen in healthy children and pregnant women. In such circumstances, angiomas are few in number and usually resolve with time. Numerous spider angiomas are seen in patients with chronic liver disease, alcoholism, and estrogen-producing tumours.



Treatment should be directed at the underlying cause. In healthy children, treatment is usually not necessary, other than for cosmetic reasons. In such cases, spider angiomas can be treated with electrocoagulation or pulsed dye laser.

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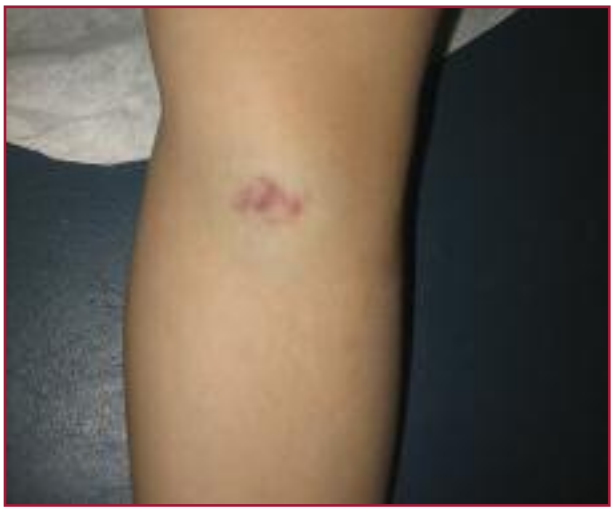
Case 4

A Growing, Congenital Plaque

A five-year-old boy presents with a history of a congenital plaque on the left shin. It has grown in proportion with his growth.



What is your diagnosis?

a. Noninvoluting congenital hemangiomas
b. Myofibromatosis
c. Juvenile xanthogranulomas
d. Congenital smooth muscle hamartomas

Answer

Noninvoluting congenital hemangiomas (NICHs) **(answer a)** are entities distinct from infantile hemangiomas. They are fully formed at birth and appear round to ovoid, are pink to purple in colour, have overlying telangiectasias and peripheral pallor. NICH also do not undergo the spontaneous involution or regression of typical infantile hemangiomas. They grow proportionally, and, therefore, appear to be a distinctive type of vascular lesion.

Myofibromatosis is characterized by fibrous nodules that occur in skin, subcutaneous tissue, skeletal muscle, and bone. The lesions are usually solitary and appear on the head and neck regions. The myofibromas, which are often present at birth, appear as flesh-coloured to purple, firm or rubbery papules, nodules, or plaques. Visceral involvement is rare when the cutaneous lesion is solitary.

Juvenile xanthogranuloma (JXG) is a benign, self-limited disease of infants and children. Skin lesions present as firm, round papules or nodules, erythematous to yellow in colour, and are most often found on the head, neck, and trunk. Lesions are asymptomatic and spontaneous resolution occurs within three- to six-years. Ocular involvement calls for immediate treatment to prevent complications, such as blindness. Children with type 1 neurofibromatosis and JXG are at higher risk for developing juvenile chronic myelogenous leukemia and, thus, should be monitored.

Congenital smooth muscle hamartoma is a benign skin lesion characterized by a proliferation of smooth muscle within the reticular dermis. These lesions present as localized, slightly elevated, flesh-coloured to faintly hyperpigmented plaques. They may be difficult to detect; however, a useful feature for diagnosis is mild, overlying hypertrichosis. Rubbing of the plaque may cause a transient pilo-erection, causing a gooseflesh-like appearance.

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Case 5

A Red, Nonhealing Lesion

A 49-year-old Caucasian female presents with a red, nonhealing lesion on her left temple. The lesion appeared approximately two years prior and has since grown to be a raised, 8 by 5 mm papule. Multiple telangiectasias are visible using dermoscopy. She indicates that she was a lifeguard for many years and was exposed to long periods of ultraviolet radiation.

What is your diagnosis?

a. Dermatoheliosis
b. Basal cell carcinoma
c. Keratoacanthoma
d. Squamous cell carcinoma

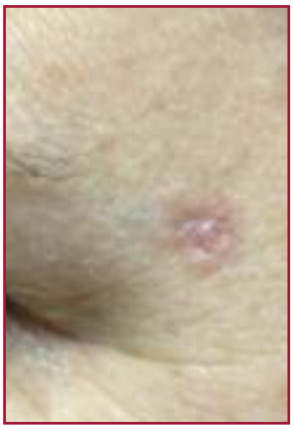

Figure 1: Nodular Basal Cell Carcinoma on the Left Temple.

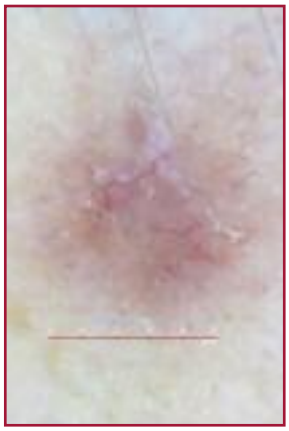

Figure 2: Dermoscopic Image of Nodular Basal Cell Carcinoma on the Left Temple, Showing Visible Telangiectasias Throughout the Lesion.

Answer

Basal cell carcinoma (BCC) **(answer b)**, principally caused by chronic exposure to ultraviolet radiation, is the most common form of skin cancer in humans. BCC is a slowly evolving, locally invasive, lesion that rarely metastasizes. Multiple lesions can occur, although isolated, single lesions are more frequent, with approximately 90% occurring on the head and neck. Patients with a history of chronic sun exposure are more likely to develop BCC later in life, with the average age of onset being over the age of 40.

Clinical diagnosis can be made by careful examination and can be enhanced by the use of dermoscopy, which is especially useful for diagnosing pigmented BCC. A biopsy can be performed in order to confirm the diagnosis microscopically or the lesion may be removed immediately by excision.

Other treatments for BCC include cryosurgery, curettage and desiccation, microscopically controlled surgery (Mohs), radiation therapy, and photodynamic therapy. Immunomodulating drugs, such as imiquimod, and chemotherapy drugs, such as 5-fluorouracil, may be used to treat BCC.

Resource
1. Wolff K, Johnson RA: Fitzpatrick's Color Atlas & Synopsis of Clinical Dermatology. 6th ed. The McGraw-Hill Companies, Inc., NY, 2009.

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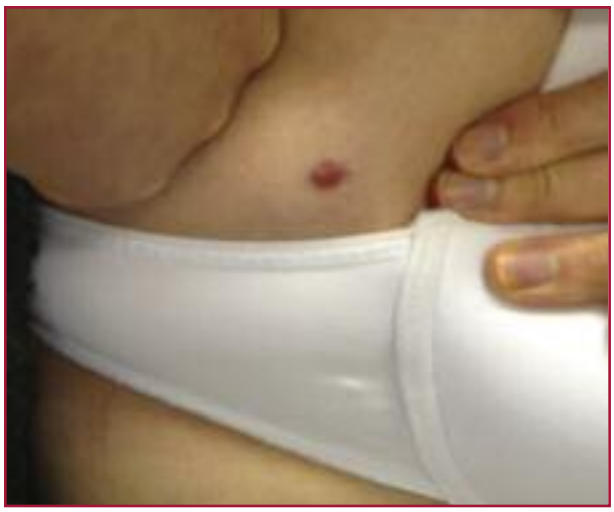
Case 6

A Nonitchy, Nontender Lump

This 36-year-old lady went to see her family physician, because she was concerned about this plump, non-itchy, non-tender lump, which she is sure was not there two months ago.

She has been very busy recently, as she just gave birth to her first baby three months ago. It was a normal, full-term, uneventful, vaginal delivery, but the baby had some initial difficulty breast feeding due to tongue tie, which has been stressful for the mother.

Her past medical history is unremarkable, apart from fibromyalgia, which was diagnosed seven to eight years ago and is currently being well treated.



What is your diagnosis?

a. Dermatofibroma
b. Pyogenic granuloma
c. Spitz nevus
d. Hemangioma
e. Malignant melanoma

Answer

A Spitz nevus **(answer c)** is a benign, dome-shaped, hairless, small (less than 1 cm in diameter) nodule that is most often pink or tan in colour. There is often a recent history of rapid growth. However, the pathology of Spitz nevus is misleading, consisting of spindle and epithelioid nevus cells, some of which may be atypical. Differentiation from nodular, malignant melanoma may, thus, require the help of a dermatopathologist who is familiar with pigment cell neoplasms.

Although the clinical appearance and recent growth are characteristic of a Spitz nevus, histologic examination must be done to confirm the clinical diagnosis. Excision, in its entirety, is important, because the condition recurs in 10 to 15% of all cases where lesions have not been excised completely.

Spitz nevi are benign, but there can be a histological similarity between Spitz nevi and melanoma, and the histopathologic diagnosis may be difficult.

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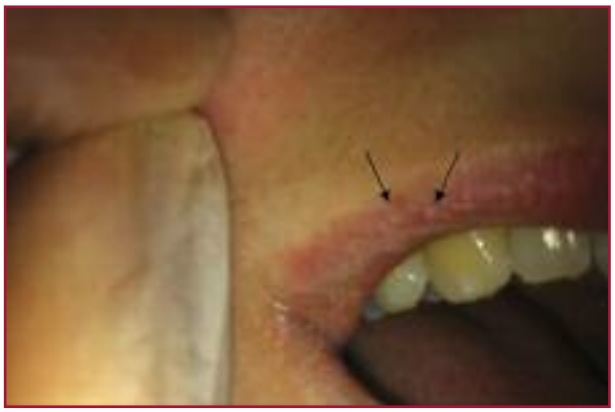
Case 7

Asymptomatic, Yellow Bumps

A 25-year-old female presents with asymptomatic, yellow "bumps" on her upper lip.



What is your diagnosis?

a. Warts
b. Molluscum contagiosum
c. Squamous cell carcinoma
d. Fordyce spots

Answer

Fordyce spots **(answer d)** are heterotopic, sebaceous glands that typically occur on the lips, but they can also be seen on the skin of the genital area. They present as multiple, discrete or confluent papules on these locations. They are considered to be a normal physiological variant and typically occur on mucosal sites. Biopsy is not required and reassurance is the only treatment necessary.

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