



Photo Diagnosis

Illustrated quizzes on problems seen in everyday practice

Case 1



Brown Thick Papules

Betty, a 43-year-old female, had numerous brown, thick papules on her trunk. So instead of seeing her physician, she went to a local ethnic pharmacy and picked up a “burning agent” which is supposed to get rid of various skin growths.

Questions

1. What is your diagnosis?
2. What is the cause of this condition?
3. What would you advise the patient?

Answers

1. Hypertrophic white permanent scarring; likely seborrheic keratoses were being self-treated.
2. The agent available in some Eastern European and Persian pharmacies/stores is a blistering or caustic agent. I have observed significant permanent scarring and a number of infections with seborrheic keratoses and skin tags, most commonly being self-treated, although many are treating moles with these concoctions.
3. There is not much that can be done for these white hypertrophic scars. The concern is if a skin cancer or dysplastic nevus is being treated this way, along with the risk of scarring and infection. Patients should be told to avoid these agents and these substances should not be made available for self-use by these stores.

Provided by: Dr. Benjamin Barankin

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Case 2



A Canal-Like Lesion

Tina, 18, presented with a canal-like lesion in both thumbs. The lesions are asymptomatic. There is no history of habitual nail biting or nail picking. There is no family history of similar nail deformity.

Questions

1. What is the diagnosis?
2. What is the significance?
3. What is the treatment?

Answers

1. Median nail dystrophy.
2. Median nail dystrophy, also known as dystrophia unguium mediana canaliformis or median canaliform dystrophy of Heller, is characterized by a paramedian canal or split in the nail plate of one or more nails. Small cracks or fissures that extend laterally from the central canal or split toward the nail edge give the appearance of an inverted fir tree or Christmas tree. The condition is usually symmetrical and most often affects the thumbs, although other fingers and toes may be involved.

The exact etiology is not known. Presumably, the condition results from a temporary defect in the matrix that interferes with nail formation. Habitual picking of the nail base may be responsible in some instances. Median nail dystrophy may result from isotretinoin therapy. Familial occurrences have also been reported.

3. Median nail dystrophy tends to resolve spontaneously over a period of months to years. No treatment is necessary.

Provided by: Dr. Alexander K. C. Leung; and Dr. Albert Y. F. Kong

Case 3



A Slow-Growing Lesion

Lisa, 64, presents with a slow growing lesion on her left forearm, now measuring 2.3 cm by 1.2 cm. Due to clinical concern for malignancy, a wide excision with primary closure is done.

Questions

1. What is the diagnosis?
2. How common is this lesion?
3. What is the treatment?



Answers

1. Histology confirms superficial basal cell carcinoma (BCC) with clear excision margins.
BCC appears as scaly patches or papules that are pink to red-brown, often with central clearing. It may appear as insidious, painless, non-healing ulcers or nodules.
2. BCC constitutes approximately 80% of all non-melanoma skin cancers. The tumours most often appear in individuals 40- to 60-years-old and on mostly sun exposed skin.
3. Curettage, cryotherapy and laser ablation may be used to treat small superficial BCC. Surgical excision with a margin of normal tissue is generally recommended for larger lesions. Excision allows for histologic examination of the specimen for confirmation of the adequacy of excision.

Provided by: Dr. Werner Oberholzer

Case 4



Pruritic Eyelids

Eugene, a 70-year-old male, presents with pruritic eyelids of several weeks duration. He is on multiple medications for diabetes and hypertension, with no drug allergies. He has no history of skin problems.

Questions

1. What is your diagnosis?
2. How would you manage this patient?

Answers

1. Eyelid dermatitis.
2. Consider a mild topical steroid twice a day for a week. Failing that, the next strongest class of topical steroid, such as desonide, can be applied. Topical calcineurin inhibitors such as tacrolimus and pimecrolimus are also good options for thin areas of skin or in chronic cases. The patient should be encouraged not to rub or scratch the area and to apply a bland moisturizer to the affected area. If the condition persists, allergic contact dermatitis can be ruled out by a dermatologist through patch testing.

Provided by: Dr. Benjamin Barankin

Case 5



Rash With Low Grade Fever

Rachel, six-years-old, developed an itchy rash on her body and face seven days ago. She had a low grade fever which preceded the rash by one day. Her four-year-old sister had a similar rash three weeks ago.

Questions

1. What is the diagnosis?
2. What is the significance?
3. What is the treatment?

Answers

1. Chickenpox (varicella).
2. Chickenpox is an infection caused by the varicella-zoster virus (VZV)—a double-stranded DNA virus of the herpesvirus group. The disease is highly contagious. The lesions start as rose-coloured macules and progress rapidly to become papules, vesicles with the classic “dew drop on a rose petal” appearance, pustules and, finally, crusts. The distribution of the lesions is typically central, with the greatest concentrations on the trunk. Characteristically, lesions are intensely pruritic and appear in crops. Mucous membranes are commonly affected. Vesicles that develop on the oral or vaginal mucosa rapidly become macerated and form shallow and painful ulcers. The most common complication associated with chickenpox is secondary bacterial infections of the skin followed by post-inflammatory scarring of the lesions.
3. The diagnosis is mainly clinical and treatment symptomatic. Oral acyclovir should be considered in high-risk individuals. Intravenous acyclovir is effective for the treatment of chickenpox in immunocompromised individuals and for serious complications of chickenpox in normal patients. To eradicate chickenpox, universal childhood immunization with varicella vaccine is the way to go. The Advisory Committee for Immunization Practices of the Centers for Disease Control and Prevention and the American Academy of Pediatrics recommend a routine two-dose varicella vaccination program for children, with the first dose administered at 12 to 18 months and the second dose at four- to six-years-of-age. The Advisory Committee on Immunization Practices further recommends two doses of varicella vaccine, four to eight weeks apart, for all susceptible adolescents and adults and a catch-up second dose for everyone who received one dose of varicella vaccine previously.

Provided by: Dr. Alexander K. C. Leung; and Dr. Albert Y. F. Kong

Case 6



A Changing Mole

Mackenzie, a 16-year-old boy, presents with a longstanding mole which has recently changed in colour. There is no family history of skin cancer.

Questions

1. What is the diagnosis?
2. What is the significance?
3. What is the treatment?

Answers

1. Halo nevus.
2. Halo nevus is a common clinical finding seen in children. Sutton first described a case in 1916. It represents a benign phenomenon whereby an inflammatory infiltrate develops around a melanocytic nevus. Clinically, there is surrounding depigmentation of the skin, hence the name. Although the cause of the immunologic reaction is not known, the subsequent inflammation results in the destruction of the melanocytes. Repigmentation of affected skin may take many months.

If this phenomenon is noted in adults, one should always consider the possibility of malignant melanoma with spontaneous regression (melanoma associated leukoderma). Suspicious lesions should be biopsied and a full skin examination with Wood's lamp evaluation for other moles should be carried out. The use of a Wood's lamp will accentuate any areas of reduced pigmentation.
3. The prognosis is excellent and most lesions resolve spontaneously. However, halo nevi should be monitored for any atypical changes such as tenderness, pruritus and bleeding to exclude malignancy. In this particular case, the halo nevus was subsequently biopsied. Pathology revealed dysplastic features, therefore local wide excision was carried out.

Provided by: Dr. Simon Lee; and Dr. Nancy Ho

Case 7

An Asymptomatic Growth


Tamara, 54, who has a long history of rheumatoid arthritis, presents with an asymptomatic growth on the top of her tongue. The lesion started to grow after she accidentally bit her tongue six months ago. She is a smoker. On examination, no local lymph nodes were found.



Questions

1. What is the most likely diagnosis?
2. What investigation and treatment are recommended?

Answers

1. A benign mucosal or submucosal lesion such as fibroepithelial polyp or papilloma.
2. Total excisional biopsy and pathology examination. 

Provided by: Dr. Jerzy K. Pawlak

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