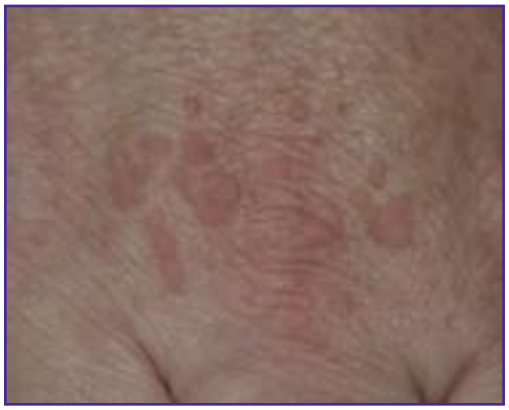
Case 1



Pink, Flat Papules

This 30-year-old male presents with a two-year history of 1 mm to 3 mm, pink, raised, flat-topped papules on his dorsal hands. The lesions were resistant to treatment with topical corticosteroids.

Questions

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

Answers

1. This patient has verruca plana (flat warts). These warts usually affect the hands, face and lower legs and appear as multiple, elevated, pink, skin-coloured or light brown, 1 mm to 5 mm, flat-topped papules, typically lacking in scale.
2. Lichen planus lesions may mimic flat warts, as lichen planus may present as small, planar, purple/red papules. However, the two conditions may be differentiated by the presence of Wickham's striae (fine white lines on surface of lesions) and buccal involvement in lichen planus.
3. Flat warts may be treated most effectively with cryotherapy, however, topical imiquimod 5%, salicylic acid or cantharidin may be tried.

Provided by: Aimee MacDonald; and Dr. Richard Langley

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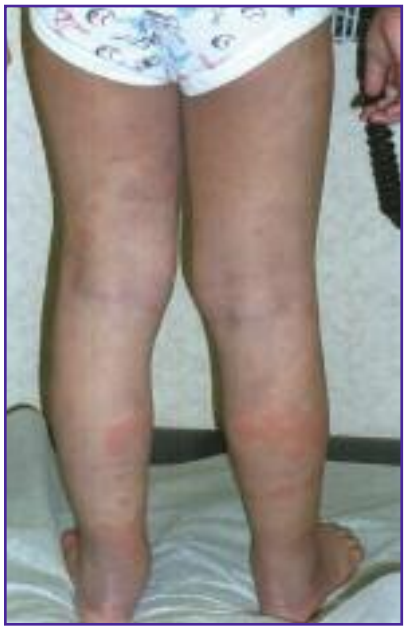
Case 2



Intensely Pruritic Rash

A nine-year-old boy presents with an erythematous rash all over his body. The rash is intensely pruritic. Individual lesions come and go.

Questions

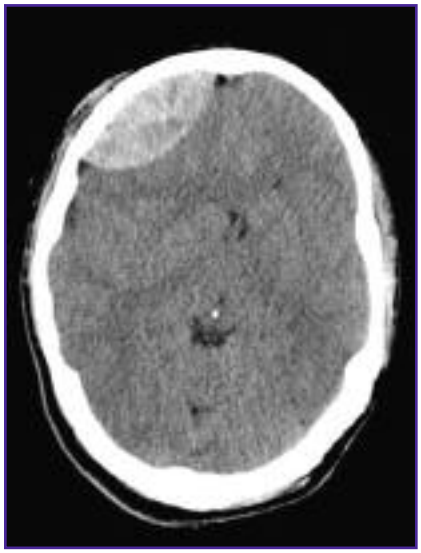
1. What is the diagnosis?
2. What is the significance?
3. What is the treatment?

Answers

1. Urticaria.
2. Urticaria is characterized by pruritic, erythematous, edematous wheals of the superficial layers of the skin. The hallmark of urticaria is that individual lesions wax and wane rapidly, usually lasting less than four hours and rarely persist > 24 hours. The lesions blanch on pressure, varying in size from a few millimeters to a few centimeters in diameter and can be localized or generalized. The majority of acute urticarias are caused by type-1, anaphylactic, IgE-mediated or immediate hypersensitivity reactions to allergens such as food (notably peanuts, eggs, chocolate) or drugs (notably β-lactam). Mast cell is the major effector cell and histamine being the major mediator. Urticaria may also result from non-immunological triggering of mast cell release such as from chemical (radiocontrast material) or physical stimuli (cold, heat).
3. Non-sedating H_1 antihistamines are the mainstays in the management. In acute severe urticaria, subcutaneous epinephrine (0.01 ml of 1:1,000 epinephrine per kg, up to 0.3 ml) is indicated.

Provided by: Dr. Alexander K. C. Leung; and Dr. Justine H. S. Fong

Case 3



History of Fall

A 53-year-old male presents with a history of fall and decline in the level of consciousness. A CT scan was performed.

Questions

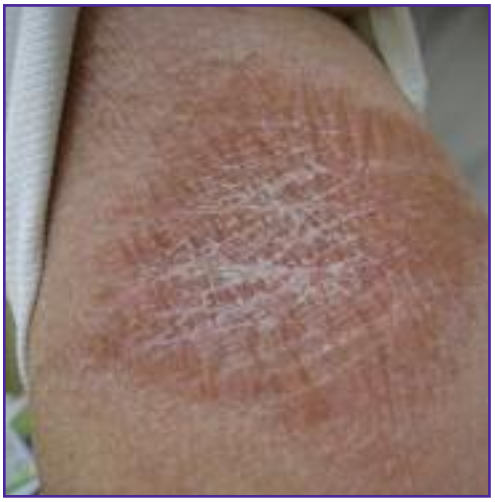
1. What is seen in this CT scan image?
2. What is your diagnosis?
3. What is the treatment?

Answers

1. This CT scan shows biconvex acute hyperdensity in right frontal area with mild mass effect and midline shift.
2. Right frontal epidural hematoma.
3. Surgical evacuation of hematoma.

Provided by: Dr. Abdul Qayyum Rana; Dr. Faisal R. Khan; and Dr. Waheed Khan

Case 4



Erythema and Lichenification

A 33-year-old female presents with a pruritic area of erythema and lichenification on her antecubital fossa. She has a history of "skin allergies."

Questions

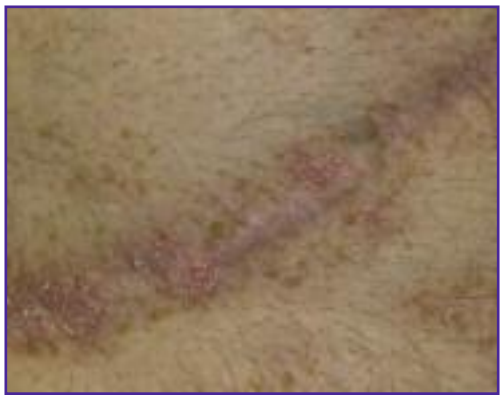
1. What is your diagnosis?
2. What areas are most commonly affected by this condition?
3. How would you manage this patient?

Answers

1. Lichen simplex chronicus, thickening of skin with some scaling due to repetitive rubbing or scratching.
2. Nape of neck, ankles, scalp, vulva and scrotum.
3. Stress and/or anxiety reduction can be helpful. Moisturizing is important, as are potent topical steroids for a few weeks, with possible transition to a topical calcineurin inhibitor (*e.g.*, tacrolimus, pimecrolimus). Oral antihistamines with sedating properties can be helpful on occasion.

Provided by: Dr. Benjamin Barankin

Case 5



A Scaling Plaque

This 61-year-old male presents with a well-defined, scaling plaque over scar tissue from a previous cholecystectomy.

Questions

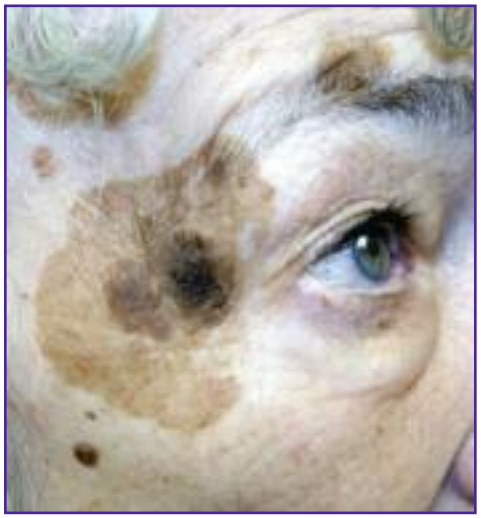
1. What is the diagnosis?
2. What is the significance?
3. What is the treatment?

Answers

1. Psoriasis, which presents as a well-defined, erythematous, scaling plaque that can affect any cutaneous surface but favours the extensors, scalp and intertriginous areas. Known triggers for psoriasis include trauma, infections, stress and certain drugs (*i.e.*, lithium, β-blocking agents, antimalarials).
2. This patient experienced a flare of his psoriasis at the site of an old surgical scar. When psoriasis occurs at the site of trauma to the skin, such as scratching, sunburns or surgery, it is referred to as the Koebner phenomenon.
3. If psoriasis is localized, topical treatment is indicated, such as corticosteroids, vitamin D analogs, tar, anthralin or combinations. For resistant or more extensive cases, phototherapy (UVA/UVB) or systemic treatments (cyclosporine, retinoids or methotrexate) may be used. Recently, biologic agents which target specific cells or cytokines in the immune system have been approved for moderate to severe chronic plaque psoriasis. These include T-cell agents (alefacept), TNF antagonists (etanercept, adalimumab, infliximab) and an interleukin-12/23 antagonist (ustekinumab).

Provided by: Aimee MacDonald; and Dr. Richard Langley

Case 6



Pigmented Lesions

An 82-year-old female presents with pigmented lesions over the right side of her face. They have been increasing in size and number for almost 30 years. Examination of the skin shows macules, patches and verrucous plaques ranging in size from 5 mm up to 3.5 cm. Some are light brown, others are medium brown.

Questions

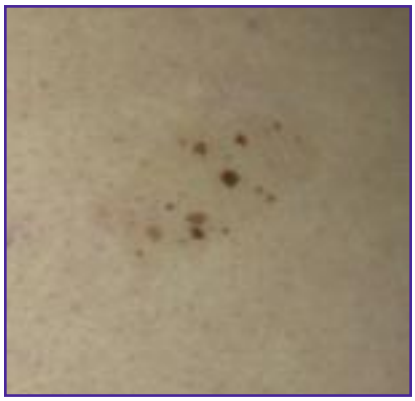
1. What is the possible diagnosis?
2. What is the significance?
3. What is the management?

Answers

1. Seborrheic keratoses, lentigos and possible lentigo maligna.
2. Lentigo, or liver spot, occurs in sun exposed areas of the face, arms and hands. The lesions vary in size from 0.2 cm to ≥ 2 cm and become more numerous with advancing age. A long-standing lentigo maligna often transforms into malignant melanoma. To rule out lentigo maligna melanoma, a biopsy should be taken from any lentigo that develops a highly irregular border, localized increase in pigmentation, or localized thickening. Seborrheic keratosis is a very common, benign, usually pigmented tumour. It occurs after 40-years-of-age, especially on the trunk and face. Early, flat lesions remind solar lentigo or spreading pigmented actinic keratosis. Larger pigmented lesions are easily mistaken for pigmented basal cell carcinoma or malignant melanoma. In such situations, only biopsy will settle this.
3. Biopsy of all suspected lesions is essential.

Provided by: Dr. Jerzy Pawlak

Case 7



Hyperpigmented Patch

A 12-year-old boy presents with an asymptomatic hyperpigmented lesion on his left upper abdomen.

Questions

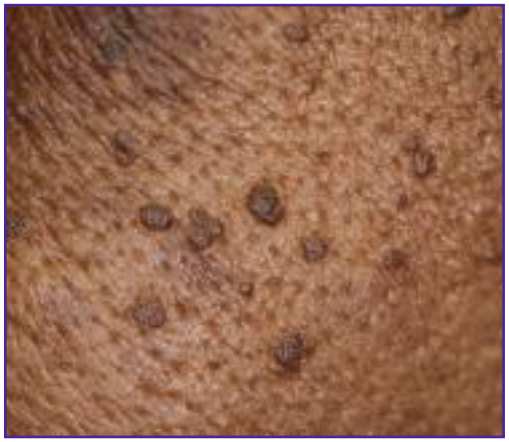
1. What is the diagnosis?
2. What is the significance?
3. What is the treatment?

Answers

1. Spilus nevus.
2. Classically, spilus nevus presents as a light-brown circumscribed pigmentation that is stippled with dark-brown punctate macules or papules. Although spilus nevus can be congenital, most lesions develop in the first year of life and some during childhood or adolescence. The lesion often starts as an evenly pigmented light-brown macule with few or no speckles. The speckles appear or increase during childhood or even adulthood. In the macular type of spilus nevus, the speckles are evenly distributed within the background macule. In contrast, the papular type shows a more scattered and uneven distribution of the speckles within the background macule. Sites of predilection include the abdomen and back. Spilus nevus usually presents as an isolated finding. Sometimes, it may occur as part of phacomatosis spilorosea, phacomatosis pigmented keratosis, or spilus nevus syndrome.
3. Although spilus nevi are generally benign, they must be followed closely so that any changes that are suspicious for malignancy can be detected; atypical melanocytic proliferations can lead to melanoma formation. This is especially true for dysplastic giant congenital nevi and those with an atypical appearance.

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

Case 8



Dark Brown Papules

A 65-year-old African-Canadian female presents with multiple, deeply pigmented papules on her cheeks. They have gradually appeared over several years.

Questions

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

Answers

1. This patient has dermatosis papulosa nigra, a variant of seborrheic keratosis, which are benign skin lesions. It presents as dark brown or black verrucous papules.
2. Dermatosis papulosa nigra have no specific medical significance, although they may be pruritic. Patients may also be concerned about their appearance.
3. No specific treatment is required; reassurance is sufficient. Caution must be exercised if using liquid nitrogen or other destructive modalities because hypo- or hyperpigmentation can occur at the site. Dx

Provided by: Kelsey A. Crawford; and Dr. Richard Langley