



Best of 2011

Illustrated quizzes on  
problems seen in everyday practice

## Case 1



## Scaly Plaque on Calf

A 52-year-old male presents with an isolated, itchy, scaly plaque on his calf. Mid-potency topical steroids have provided some relief, but the lesion remains.

### Questions

1. What is your diagnosis?
2. How can you confirm the diagnosis?
3. How would you manage this patient?

### Answers

1. Tinea incognita. The use of a topical steroid on a fungal infection may improve erythema and pruritic symptoms; however, in the meantime, the fungal infection slowly progresses.
2. A skin scraping, with potassium hydroxide examination and fungal culture, would confirm the diagnosis. A biopsy should also reveal the diagnosis.
3. Topical antifungals twice per day for three to four weeks should resolve the lesion. Adding a mild topical steroid can also assist with the pruritus.

Provided by: Dr. Benjamin Barankin

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### Case 2



## *Visual Field Loss*

A 67-year-old man presents with a two-month history of headaches and peripheral visual field loss.

### Questions

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

### Answers

1. Papilledema
2. Papilledema refers to swelling of the optic disc margins, secondary to raised intracranial pressure.
3. Urgent neuroimaging (head CT or MRI) and ophthalmic consultation are required to rule out an intracranial lesion.

Provided by: Mr. Sean A. Kennedy and Dr. Jason Noble

## Case 3



## Nodules on Penis

A 22-year-old male presented to the clinic with a ten week history of a gradually developing intense pruritic eruption on the trunk, arms, hands, legs, and penis. Pruritus is worse at night, and one of his brothers has similar complaints. On his penis, brownish-red nodules are present on the shaft and scrotum.

### Questions

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

### Answers

1. Scabies, a mite skin infestation. *Sarcoptes scabiei* is spread by skin-to-skin contact and causes a generalized intractable pruritus with frequent secondary bacterial infection.
2. Apply antiscabetic cream for 12 hours; however, application on the head should be avoided. Clothes and bedding should be thoroughly washed. All these measures should be taken by all family members.

Provided by: Dr. Jerzy Pawlak and Mr. Pawel Utko

### Case 4



## Scalp Mass

A 15-year-old girl presents with a mass on the scalp, which her mother noted a few years ago. The lesion is soft and light brown in colour. Rarely, it bleeds when hair is combed.

### Questions

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

### Answers

1. Congenital melanocytic nevus
2. Congenital melanocytic nevi refer to melanocytic nevi present either at birth or within the first few weeks of life. The incidence ranges from 1 to 2% for any size of congenital melanocytic nevi, to around 1 in 20,000 for giant ones. The majority of congenital melanocytic nevi are intradermal or compound in nature. The colour varies from light to dark brown. The majority of the lesions are palpable but reasonably flat at birth. In this case, the lesion has gone unnoticed for many years, as it is obscured by hair. With time, congenital melanocytic nevi tend to become more elevated, and coarse dark hair growing from the nevus may become prominent. Congenital melanocytic nevi may be cosmetically disfiguring. Erosions or ulcerations may occur, especially in giant congenital melanocytic nevi. Congenital melanocytic nevi also predispose affected patients to the development of melanoma.
3. The “watch and wait” approach is usually adopted for small- and medium-sized congenital melanocytic nevi. When deciding whether or not to excise the lesion, cosmetic and psychosocial issues, the potential for malignant transformation, ease of clinical follow-up, complexity of removal, risk of surgery, and functional outcome must be considered. The management must be individualized for each patient.

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

Case 5



## *A Horn-like Papule*

This 74-year-old man presents with a crusted, horn-shaped papule on the lower lip.

### Questions

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

### Answers

1. This patient has a cutaneous horn, classically defined as a keratinized projection with a height that is at least one-half of its diameter. Lesions most commonly occur on the face, ears, and hands and in light-skinned individuals over 50-years-of-age. Clinically, cutaneous horns present as white or yellow keratinized projections ranging from several millimetres to several centimetres in length. They can vary in shape and may be cylindrical, conical, or curved.
2. The base of the cutaneous horn may be composed of benign pre-malignant or malignant skin conditions; the most common conditions are seborrheic keratosis, verruca vulgaris, molluscum contagiosum, actinic keratosis, and squamous cell carcinoma. Biopsy of the base of the lesion is important to determine if there is a malignancy present.
3. Treatment will depend on the type of lesion diagnosed by histological examination. Complete excision may be recommended if the lesion is found to be malignant. Excisional biopsy is favoured, as it preserves the lesion and base for histopathology. Follow-up is recommended in the case of non-melanoma skin cancer to screen for recurring basal or squamous cell carcinomas.

Provided by: Ms. Lesley Latham and Dr. Richard Langley

### Case 6



## *Purple Blister*

A 30-year-old male presents with a violaceous, hemorrhagic bulla on his left fifth digit. He has no recent history of injury to the hand, but he had a wart treated by another physician before developing the condition.

### Questions

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

### Answers

1. This lesion is a hemorrhagic bulla resulting from cryosurgery (liquid nitrogen treatment), which was used to treat a common wart.
2. Common warts (verruca vulgaris) typically appear as dome-shaped, gray-brown hyperkeratotic papules or plaques with black dots representing thrombosed capillaries. Cryosurgery is commonly used to treat warts. Before applying the liquid nitrogen, the hyperkeratotic material should be pared. Liquid nitrogen is then applied with either a spray or a cotton-tipped applicator to freeze a 1 to 2 mm zone around the wart. Maintain the liquid nitrogen on lesional skin for approximately five seconds. A small blister, and sometimes hemorrhage, is expected as a result of this treatment. Excessive and prolonged freezing can result in a larger hemorrhagic blister, which eventually heals with scarring.

Provided by: Ms. Jessica Corbin and Dr. Richard Langley

## Case 7



## *Eczematous Eruption*

A 45-year-old male presents with a several year history of a pruritic right forearm rash that is erythematous and flaky. He was treated with short courses of topical steroids and antifungals in the past with no improvement to his condition.

### Questions

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



### Answers

1. Lichen simplex chronicus
2. This disorder is caused by persistent and chronic itching and scratching that can be secondary to pruritic skin conditions (*i.e.*, eczema). The itch-scratch cycle can also occur without a primary skin condition. The recurrent trauma from scratching causes the skin to undergo lichenification.
3. The primary treatment for lichen simplex chronicus is to discontinue scratching. Topical therapy to control the primary lesions and pruritus should be considered and may include antihistamine or corticosteroid medications. Topical salicylic acid may be used to break down excess keratin in the lesions. A reasonable therapeutic course for this patient would be Diprosalic ointment (betamethasone with salicylic acid) applied topically b.i.d. for four to six weeks.

Provided by: Mr. John Taylor and Dr. Karen Choi

Case 8



## *Plaques on Eyelids*

A 44-year-old female developed yellowish plaques near the medial canthi of both the upper and lower eyelids five months ago. Her recent bloodwork shows normal serum lipids.

### Questions

1. What is the diagnosis?
2. What is the pathogenesis of the condition?
3. What is the management?

### Answers

1. Xanthelasma palpebrarum
2. Approximately 50% of the lesions are due to elevated plasma lipid levels, with altered lipoprotein composition or structure. It is not clear why xanthelasma palpebrarum also develops in patients with normal serum lipids.
3. The underlying lipid disorder should be identified and treated by dietary and lifestyle modifications as well as pharmacologic methods if appropriate. Treatment of the lipid disorder, however, may show limited results in the clearance of xanthelasma palpebrarum. Xanthelasma palpebrarum may be removed electively by chemical cauterization, electrodesiccation, laser ablation, or surgical excision. Patients should be warned about potential side effects, including scarring, pigmentary changes, and recurrence, which are not uncommon.

Provided by: Dr. Francesca Cheung



Case 9




## Tongue Mass

A 71-year-old gentleman presents with a three-week-history of a painless mass on the bottom of his tongue. There is no history of smoking, alcohol, or tobacco use. Surgical resection was completed due to a concern of malignancy.

### Questions

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

### Answers

1. Histologically confirmed squamous cell carcinoma (SCC). SCC typically appears as a raised, firm, pink- to flesh-coloured keratotic papule or plaque. Surface changes may include scaling, ulceration, or crusting.
2. SCC accounts for 95% of all oral cavity cancers. The tumour most often occurs in male patients between the ages of 50 to 60 with a positive smoking, alcohol, or tobacco use history. Recent studies have shown that HPV can account for up to 25% of all oral cavity tumours.
3. Surgical resection with possible neck dissection and free flap reconstruction is often the treatment of choice with post-operative radiation therapy. However, radiation may be used alone for elderly patients or large unresectable tumours. 

Provided by: Dr. Werner Oberholzer and Mr. Han Zhang