

## QUESTIONS-RÉPONSES/QUESTIONS AND ANSWERS MACULAR ERUPTION

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### THE CASE



*A 17-year-old male presented on March 12, with a 2-day history of skin lesions over the trunk (Figure). The lesions are erythematous with scaly borders. He had an upper viral infection 8 days before developing these lesions. There is no history of sexual activity, and he did not receive any medication. This is the first time he develops this picture. There is no past or current similar history in family members.*

The most likely diagnosis is :

- A. Tinea corporis
- B. Eczema
- C. Pityriasis rosea
- D. Psoriasis
- E. Secondary syphilis

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## DISCUSSION

The differential diagnosis includes all the options [1]. The absence of sexual activity rules out syphilis. The fact that this is the first episode makes eczema and psoriasis less likely. Tinea corporis usually presents with central clear lesion and elevated border ; potassium hydroxide smear may help to differentiate this entity [1]. Several medications and massage with mustard oil may cause a rash similar to that depicted in the photo ; always ask about medication history and local use of any product [2].

The most likely diagnosis is pityriasis (scaly) rosea (red) (PR). PR is more likely to appear in fall and spring in persons between 10 and 35 years of age [1].

The etiology of PR is not clear though some think that viral infection plays a role. In 20-69% of patients PR is preceded by upper respiratory viral infection [3-4]. Some patients were found to have elevated B lymphocytes and outbreaks of PR occur [3].

In 40-76% of cases a herald (mother) patch – a bigger oval to round lesion around 5 cm in diameter – appears 1-2 weeks prior to the rash [5]. The lesions are papular, oval in shape with scales and parallel the skin cleavage lines. The number of lesions can vary from few to hundreds and may last up to 8 weeks. Over the back the lesions have a “Christmas tree” appearance [3].

The lesions are most of the time asymptomatic. Reassurance is all what is needed [1, 3, 5]. Erythromycin

in one prospective, poorly randomized study showed marked shortening in the duration of symptoms compared to placebo. However, this modality is still under investigation [5]. It is important to inform the patient that the lesions are not contagious. Lesions will eventually heal with no scarring. PR is not a manifestation of a co-morbid condition [1]. If pruritis develops then symptomatic treatment with systemic antihistamine may be indicated.

PR can be managed by the primary care physician. Referral is indicated if the lesions do not disappear within 8 weeks [1].

## REFERENCES

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## ADDENDUM TO QUESTIONS AND ANSWERS published in Volume 53 (3), pp. 185-186



FIGURE 2

Abnormal X-ray of the paranasal sinus :  
Air-fluid level (*thick arrow*), mucosal thickening (*thin arrow*).

Due to a technical error the second radiological picture was not included in the discussion. Although not absolutely essential we deem this X-ray useful to a better understanding of the case.