

When You Can't Make a Rash Diagnosis



Joe R. Monroe, MPAS, PA, practices at Dermatology Associates of Oklahoma in Tulsa. He is also the founder of the Society of Dermatology Physician Assistants.

For years, this 64-year-old man has complained of itching and a rash around his head and neck. He has consulted several primary care providers—and even a dermatologist. A punch biopsy performed by that provider yielded no clear diagnosis. The patient was advised to return for follow-up but never did so.

Treatment was attempted with a succession of medications; none resulted in any improvement. The list includes antifungal creams (econazole, clotrimazole, and miconazole), an oral antifungal medication (a one-month course of terbinafine 250 mg/d), and a corticosteroid (a one-month course of prednisone 20 mg/d).

In addition to the rash and pruritus, the patient feels “lumps” in the affected areas. He also reports feeling more tired than usual. Prior to the onset of these symptoms, his only complaint was lifelong eczema.

Large infiltrative plaques are seen on both sides of his neck, extending into his

ears and onto his scalp. A few exceed 8 cm in diameter, and all have smooth surfaces with no epidermal disturbance. Several discrete, 2- to 4-cm, fixed nodules are also seen and felt on his neck below these plaques.

A 5-mm punch biopsy is performed on one of the plaques on his occipital scalp; the pathology report shows only chronic changes consistent with eczema. The decision is made to perform another biopsy. A deeper, wider, 5-cm wedge from the left preauricular plaque is taken and submitted. The report shows changes consistent with tumor-stage mycosis fungoides (MF).

Which of the following statements is false?

- a) MF is almost always fatal.
- b) Tumor-stage MF is potentially fatal.
- c) MF is one of the few skin cancers that can take years to advance to the tumor stage.
- d) This diagnosis requires referral to oncology.

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ANSWER

The false statement—and therefore the correct choice—is that MF is almost always fatal (choice “a”). MF can often be controlled, if not completely cured.

DISCUSSION

In its early stages, cutaneous T-cell lymphoma (CTCL) can manifest with an innocuous-appearing rash, notable for its chronicity and resistance to treatment. One example is *poikiloderma vasculare atrophicans* (PVA), which is identified by nonblanchable atrophic patches with fine surface vascularity that often manifest around the waistline or groin. Left undiagnosed and untreated, PVA can slowly progress to a more advanced stage, as was the case with this patient.

Several cancers can present with rash,

including extramammary Paget disease, superficial squamous cell carcinoma (Bowen disease), and various types of metastatic cancer (eg, breast, colon, lung).

The confirmation of CTCL/MF may require serial biopsies over time, as the diagnostic signs can take years to become detectable. These specimens must be accompanied by pertinent clinical information to suggest a differential that includes this lymphoma.

Early-stage CTCL can be controlled with topical steroids, but as the condition advances, specialized treatment is needed. The tumor stage observed in this patient predicts an uncertain prognosis; further workup is required to determine the extent of the disease, as well as advanced treatment to control it. **CR**