There's More Where That Came From

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About 10 days ago, an asymptomatic, scaly lesion arose overnight on this 21-year-old man's upper left chest, near the anterior deltoid area. Within the past week, multiple scaly lesions—much smaller than the original—have appeared on his trunk and arms.

The patient claims to be in good health otherwise, denying fever, malaise, or myalgia. He denies sexual contact of any kind in the past two months. There is no personal or family history of skin disease or atopy.

On exam, the patient looks his stated age, is afebrile, and is in no acute distress. On his chest is an oval, pinkish brown, papulosquamous lesion with very fine, sparse scaling in the center. The long axis of the lesion parallels local skin tension lines.

About 20 additional lesions are observed elsewhere, primarily on the truncal skin, sparing the upper neck, face, and palms. All are oval, with the same odd color and scale, and follow skin tension lines. The patient's elbows, knees, scalp, and nails are unaffected, as are the areas around and below the waist.

The most likely diagnosis is
a) Fungal infection
b) Psoriasis
c) Secondary syphilis
d) Pityriasis rosea

ANSWER

The correct answer is pityriasis rosea (choice "d").

Virtually all patients with this condition believe that they have a terrible case of "ringworm" (ie, fungal infection; choice "a")—an opinion all too often corroborated by the medical provider unacquainted with pityriasis rosea. The two can be difficult to distinguish, but the "herald" patch, oval shape, odd color, and fine scale all serve to confirm the diagnosis. When necessary, a KOH prep or biopsy can be done.

Psoriasis (choice "b") can manifest acutely, but it is distinctly salmon-pink under coarse, white scale that affects the

palms, nails (with pits), and scalp. Psoriasis lesions are round (rather than oval), with coarser scale and without a herald patch.

The lack of antecedent sores and denial of sexual contact ruled out secondary syphilis (choice "c"). Patients with secondary syphilis often present with low-grade fever, malaise, and palmar scaly papules—all of which were missing in this case. Syphilis serology (rapid plasma reagin) can be easily obtained if doubt persists.

DISCUSSION

Pityriasis rosea (PR) is a papulosquamous eruption that is common in younger populations. About 40% of affected patients present with a large scaly lesion, which is followed by the appearance of multiple smaller oval lesions within days. In most cases, PR is fairly easy to diagnose: the lesion's oval shape, pinkish-brown color, centripetal fine scale, herald patch, and adherence to skin tension lines are all characteristic findings.

Though the exact organism has not been identified, PR is almost certainly viral in origin. Like many viral exanthems, occurrence tends to peak in the spring and fall. There are also indications that the body builds immunity to the infection, since recurrence outside the acute phase is rare.

Treatment options are unsatisfactory, though exposure to UV sources appears to help. Patients must be informed that their condition will, unfortunately, last for at least six to nine weeks, during which crops of lesions will come and go. **CR**