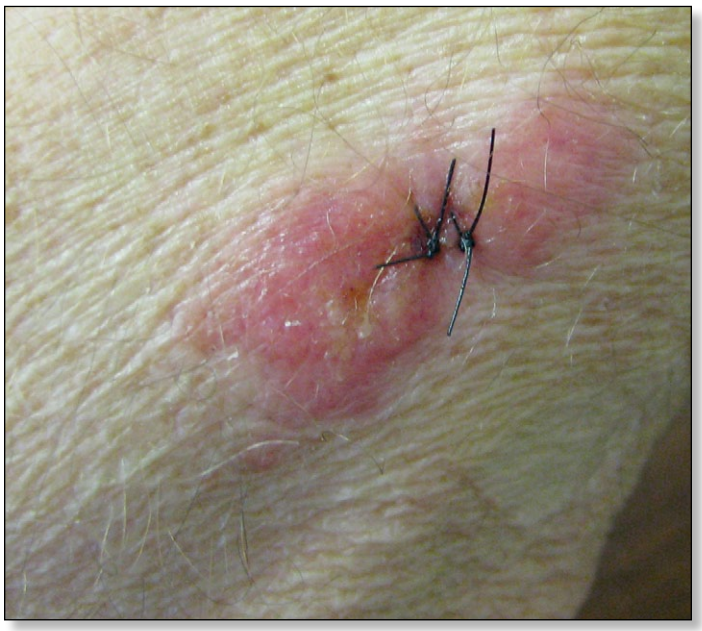
DIAGNOSIS AT A GLANCE

Stephen M. Schleicher, MD, Eva F. Goyette, DO, and Amy Hendrix, CRNP

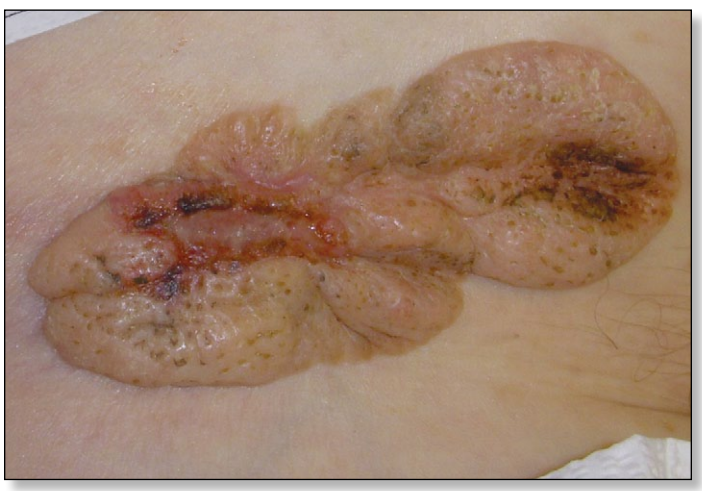


Case submitted by Drs. Schleicher and Goyette.

CASE 1

A 56-year-old man has scattered lesions on both arms. They first arose 3 weeks ago and are asymptomatic. He denies fever, chills, malaise, or swollen lymph nodes. Approximately 1 month prior to the onset of the lesions, the patient spent a week bird-watching in a Costa Rican rainforest. He reports that while he was there, he was bitten by mosquitoes; however, he cannot recall the precise location of the bites. Examination reveals five erythematous, indurated plaques, two with central ulceration devoid of exudate. A 1-week course of clobetasol cream is prescribed but proves ineffectual. During the course of this treatment, the patient reports via e-mail that a companion on the trip has developed a similar condition. The patient is instructed to return for biopsy.

What is your diagnosis?



Case submitted by Dr. Schleicher and Ms. Hendrix.

CASE 2

An 88-year-old man presents for evaluation of a sizable lesion situated on his right lower abdomen. He resides in a nursing home and is unable to provide a detailed history. According to an attendant at the facility, the patient has been observed scratching the area. On occasion, this action induces bleeding. Examination reveals a 5 × 2–cm, well-demarcated, flesh-colored, exophytic plaque with a somewhat rugose consistency. Multiple pinpoint depressions resembling open comedones are also noted, in addition to superficial ulceration at both lateral poles. Inguinal lymph nodes are nonpalpable.

What is your diagnosis?

Dr. Schleicher is director of the DermDOX Center in Hazleton, Pennsylvania, a clinical instructor of dermatology at King's College in Wilkes-Barre, Pennsylvania, an associate professor of medicine at the Commonwealth Medical College in Scranton, Pennsylvania, and an adjunct assistant professor of dermatology at the University of Pennsylvania in Philadelphia. He is also a member of the EMERGENCY MEDICINE editorial board. **Dr. Goyette** is a family practice resident at Westchester General Hospital in Miami, Florida. **Ms. Hendrix** is on the staff at Reading Dermatology Associates in Pennsylvania.

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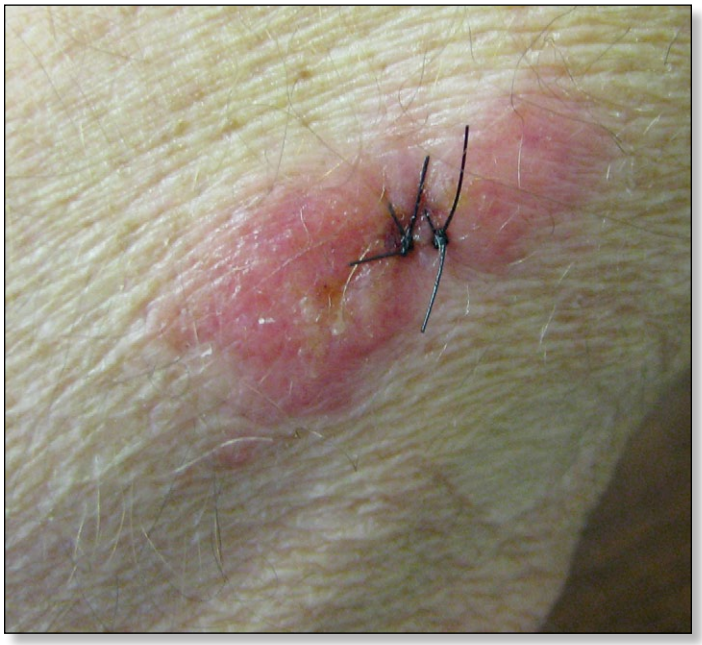
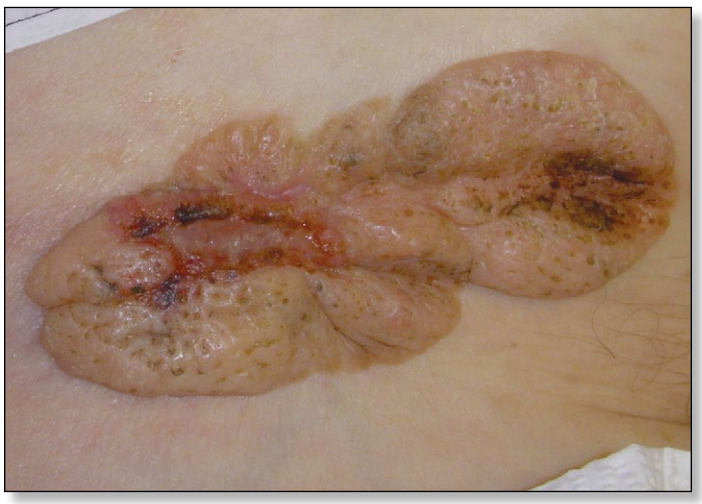


CASE 1

Cutaneous leishmaniasis is transmitted through the bite of a sandfly—which, at half the size of a mosquito, can readily pass through mosquito netting. In Costa Rica, the disease is endemic solely to the tropical rainforests. The incubation period ranges from 2 to 8 weeks, and the first sign of disease is an erythematous papule, which slowly enlarges into a painless plaque or nodule that ulcerates. Diagnosis is based on clinical appearance of the lesions, with any history of visitation to an endemic area taken into consideration. Biopsy may reveal evidence of the parasite, although the diagnostic gold standard is PCR (polymerase chain reaction) assay. Untreated lesions may slowly resolve over a period of weeks to months, often with some degree of scar formation. This patient was treated with both local cryosurgery and topical application of paromomycin ointment.



CASE 2

Eccrine porocarcinoma is an extremely rare malignant tumor arising from eccrine sweat glands. Fewer than 200 cases have been reported in the literature. The most commonly affected site is the lower extremities, followed by the trunk. The majority of cases occur in individuals ages 60 to 80 years. The clinical appearance ranges from a dome-shaped nodule to an exophytic, ulcerated plaque, as seen in this case. The differential diagnosis includes amelanotic malignant melanoma, squamous and basal cell carcinoma, and extramammary Paget disease. The tumor has a tendency to recur following excision, and metastatic spread to skin and/or regional lymph nodes may occur in up to 20% of cases.