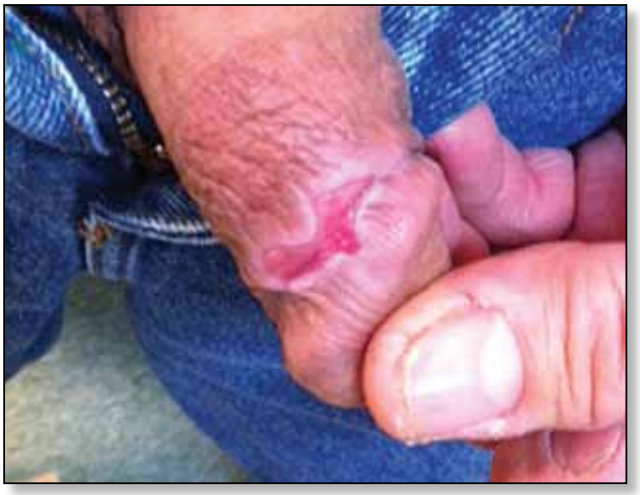
Diagnosis at a Glance

John Movassaghi, MD, and Stephen Schleicher, MD

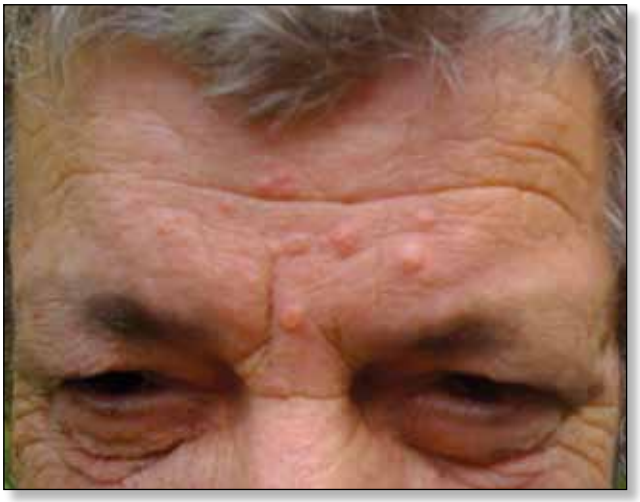


CASE 1

A 46-year-old sexually active, divorced man presents to the ED shortly after midnight for evaluation of a sore on his penis. He is noted to be intoxicated and provides a contradictory timeline regarding duration of the lesion. He denies recent travel abroad, male sexual contact, pain, or drainage at the site, as well as any antecedent trauma and blisters. A rapid plasma reagin (RPR) test performed at another ED 6 days earlier was negative, and a complete blood count was unremarkable.

Examination reveals an irregularly shaped denuded erosion of the distal penile shaft. No other lesions are noted elsewhere; there is no rash on the palms or soles; and there are no palpable lymph nodes. The photo on the left was taken by the treating ED physician and sent by e-mail to an off-site consulting dermatologist.

What is your diagnosis?



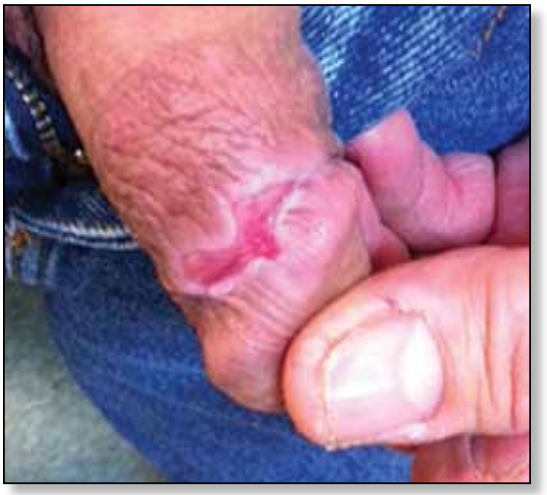
CASE 2

A 69-year-old man presents to the ED for evaluation of an ankle sprain. During intake, multiple papules are noted on his forehead and cheeks. Patient states the papules developed approximately 2 years ago and, with the exception of occasional trauma while shaving, are asymptomatic. He denies any family history of skin disorders, including skin cancer. Examination reveals multiple flesh-colored to slightly yellowish 2- to 3-mm papules of the affected areas. Several lesions have a central umbilication, and magnification reveals occasional telangiectasias.

What is your diagnosis?

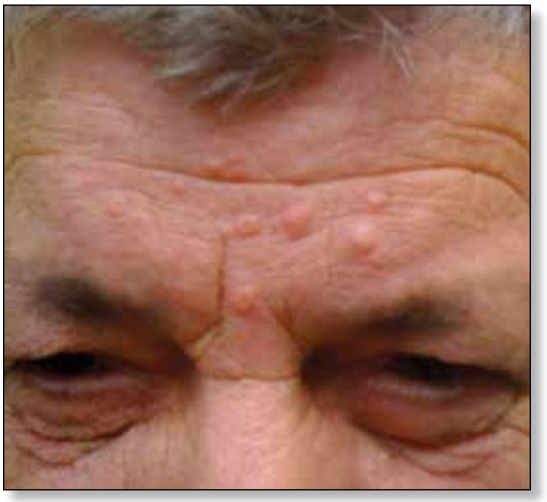
Dr Movassaghi is a staff physician at Lebanon VA Medical Center in Pennsylvania. **Dr Schleicher**, editor of "Diagnosis at a Glance," is director of the DermDOX Center in Hazleton, Pennsylvania, a clinical instructor of dermatology at King's College in Wilkes-Barre, Pennsylvania, an associate professor 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.

ANSWER



CASE 1

Differential diagnosis of a penile erosion includes sexually transmitted infections (STIs) such as syphilis, herpes, chancroid, and lymphogranuloma venereum. The most common noninfectious cause is trauma, which is the suspected diagnosis in this patient. Neoplasia should always be considered when a lesion fails to heal. As this case illustrates, medical history is often unreliable. Specific tests for STIs include serology for syphilis and culture for herpes simplex virus. Even after thorough evaluation, however, many cases of genital ulceration have no laboratory-confirmed diagnosis, and the clinician often treats for a condition that best fits physical examination and local epidemiology. Because an RPR test may yield a false-negative result during the chancre stage of syphilis, and based on patient's altered mentation, unreliable history, and concerns of noncompliance, penicillin was administered. The patient was then discharged with a referral to an STI clinic for follow-up care.



CASE 2

Sebaceous hyperplasia is a benign condition resulting from an overgrowth of sebaceous glands. Each lesion is associated with a hair follicle situated at the root of the umbilicated center. The condition commonly occurs in middle age and older and is characterized by the appearance of asymptomatic flesh- to orange-yellow-colored papules. The most common areas of involvement are the cheeks, forehead, and nose. These lesions have no malignant potential but may clinically resemble basal-cell carcinoma. Although not clinically indicated, treatment with either shave excision or electrodessication is usually sought for cosmetic reasons. Cryosurgery with liquid nitrogen has also proved effective in treating this condition