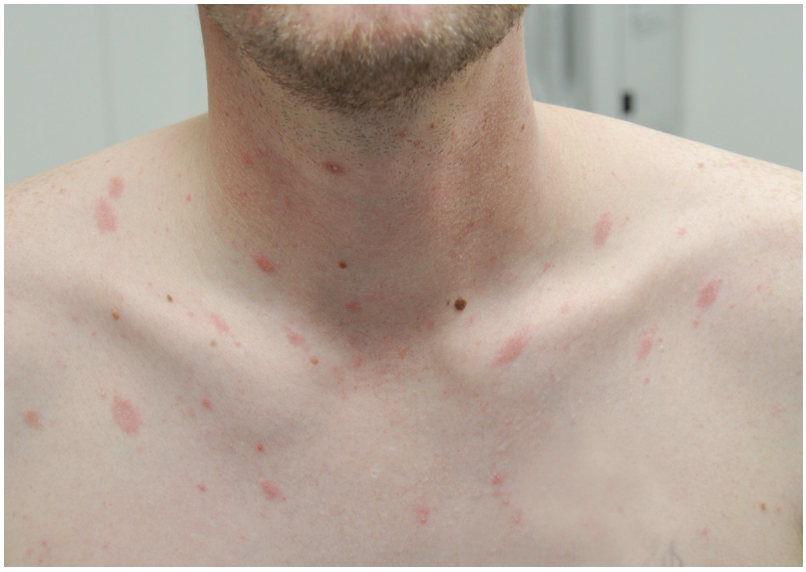
Itchy Lesion Heralds Pervasive Problem

Two weeks ago, an itchy rash appeared on a man's back before spreading to his chest and neck. He has never experienced anything like it before, and no one else in his household is similarly affected.

He denies night sweats, fever, and malaise but reports that he was recently diagnosed with rheumatoid arthritis. His rheumatologist started him on methotrexate (12.5 mg/wk) after extensive labwork (complete blood count, complete metabolic panel, and hepatitis profile) was performed. He denies any history of high-risk sexual behavior or exposure, exposure to animals or children, or history of foreign travel.

The patient, who appears well, is afebrile and in no distress. The original lesion, on his upper left back, is distinctly pinkish brown and round, with an odd fine scale around its inner rim, and measures about 3 cm in diameter.

Elsewhere, examination reveals about 15 more lesions. All are oval but similarly pinkish brown, averaging about 2 cm in their long axis. These smaller lesions form a necklace-like configuration, paralleling the natural skin lines of the neck. Each lesion has central scaling identical to that of the original back lesion.



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Examination of the patient's palms and soles fails to reveal any cutaneous abnormalities. Likewise, examination of the oral cavity is normal. No palpable nodes are felt around the neck, in the axillae, or in the groin.

Given the facts as presented, this is clearly a case of

a) An allergic reaction to methotrexate
b) Pityriasis rosea
c) The mother of all fungal infections
d) Secondary syphilis

ANSWER

The correct answer is pityriasis rosea (choice "b"), a common and very distinctive eruption related to human herpesvirus 6 and 7.

Allergic reaction to methotrexate (choice "a"), while far from unknown, does not resemble pityriasis rosea. It also would not be limited to such a relatively small area.

Pityriasis rosea is often designated as "fungal infection" (choice "c") by the uninitiated. However, the lesions of dermatophytosis would be round, with a leading scaly edge, and unlikely to be found in this distribution.

Secondary syphilis (choice "d") is a major item in the pityriasis rosea differential, but it almost always involves the palms and soles and the lesions would be round (not oval) scaly brown papules. Furthermore, assuming we have an honest patient, we're also missing a source for sexually transmitted infection.

DISCUSSION

One could hardly ask for a more classic case of pityriasis rosea (PR), which primarily affects patients ages 14 to 40. Alas, that being said, one cannot depend on

seeing all these clues in every PR patient.

For example, the herald patch (also known as the *mother patch*) is missing in at least half of cases. In others, the lesions are smaller, sparser, and more papular (especially in young black patients). The condition may even be confined to intertriginous areas (eg, the groin and/or axillae); this is known as *inverse PR*.

While salmon-colored scaly lesions are considered a classic presentation, PR can present with darker ovoid macules that have minimal scale and, rarely, become bullous. Involvement above the neck is rare.

What is consistent and dependable among signs of PR is the centripetal scale, seen even in the smallest lesions. This scale is so fine that the old dermatology texts called it "cigarette paper" scale or "scurf."

After decades of speculation, researchers finally provided strong evidence of the probable cause of PR: replication of human herpesvirus 6 and 7, present in mononuclear cells of lesional skin. Though universally acquired in childhood, these viruses are thought to remain latent until reactivated, leading to viremia.

Itching can be moderately severe in a minority of cases. Most patients, such as this one, are not bothered much by the condition once they understand its self-limited nature. They usually are not happy, however, to learn that it could persist for nine weeks or more, whether treated or not.

UV light exposure can be helpful in hastening PR's departure, and topical corticosteroids (class III or IV; eg, triamcinolone 0.1% cream) can help control the itching. Neither oral nor topical antihistamines will help, since PR is not a histamine-mediated problem.

If the diagnosis is in doubt, a punch biopsy could at least rule out the more serious items in the differential, which include syphilis, drug rash, and psoriasis. In cases in which fungal origin is a possibility, a quick KOH prep will settle the issue. However, it must be remembered that one doesn't just "get" a fungal infection. There has to be a source (animal, child), and that source is usually identified with minimal history taking. **CR**