



## Cutaneous eruption on chest and back

The cause of this “dirty” rash was fairly obvious to us, but only because we’d encountered this rare skin disorder before.

A 22-YEAR-OLD AFRICAN AMERICAN MAN sought care at our clinic for an asymptomatic, “dirty-looking” rash on the epigastrium that had expanded and thickened over the previous 2 years. The rash hadn’t responded to scrubbing with soap and water, ammonium lactate lotion 12% BID, or over-the-counter moisturizing lotions.

Brown, hyperkeratotic papules and plaques with central confluence and a pe-

ripheral reticulated appearance covered a 30 × 20 cm area on the patient’s upper abdomen and lower chest at the midline (FIGURE). A similar, milder rash appeared in a 6 cm area at the midline of his upper back.

- WHAT IS YOUR DIAGNOSIS?
- HOW WOULD YOU TREAT THIS PATIENT?

### FIGURE

A cutaneous eruption that did not respond to ammonium lactate lotion



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There is a high rate of recurrence of confluent and reticulated papillomatosis in patients after systemic antibiotics are discontinued.

### Diagnosis: Confluent and reticulated papillomatosis

This patient was given a diagnosis of confluent and reticulated papillomatosis (CRP) based on the clinical presentation.

Although this condition is uncommon,<sup>1</sup> we see it at least once a month in our dermatology clinic. CRP is characterized by centrally confluent and peripherally reticulated scaly brown plaques and papules that are cosmetically disfiguring.<sup>1</sup>

CRP usually is asymptomatic<sup>2</sup> and primarily affects young adults—especially teenagers.<sup>3</sup> It occurs in both males and females<sup>3</sup> and it commonly occurs on the trunk.<sup>1,2</sup>

CRP is believed to be a disorder of keratinization. *Malassezia furfur* may induce CRP's hyperproliferative epidermal changes, but systemic treatment that eliminates this organism does not clear CRP.<sup>3</sup>

### Differential diagnosis includes acanthosis nigricans

**Acanthosis nigricans (AN)** shares similar “dirty” brown, confluent textural plaques, as well as nonspecific acanthosis and papillomatosis on histopathologic examination. However, AN affects flexural areas, whereas CRP typically is found on the epigastrium, central chest, and central back.<sup>1,2</sup>

■ **Tinea versicolor (TV)** and CRP are both brown in color, and occur in a similar distribution on the central back and chest.<sup>4</sup> However, in contrast to the fine perifollicular scaling seen in TV, CRP is associated with textural, confluent plaques. TV also can be distinguished by its pathognomonic “spaghetti and meatball” pattern of hyphae and spores on potassium hydroxide (KOH) preparation; KOH will be negative in patients with CRP. When a presumed case of TV does not respond to antifungal therapy, CRP should be considered.<sup>1</sup>

### Making the diagnosis

A CRP diagnosis is made based on clinical presentation. The eruption usually begins as verrucous papules in the inframammary or epigastric region that enlarge to 4 to 5 mm in diameter and coalesce to form a confluent plaque with a peripheral reticulated pattern.

CRP can extend over the back, chest, and abdomen to the neck, shoulders, and gluteal cleft. CRP does not affect the oral mucosa and rarely involves flexural areas.<sup>2</sup> Although most cases are asymptomatic, mild pruritus may occur.<sup>1,2</sup>

■ **A skin biopsy rarely is necessary** for making a CRP diagnosis, but histopathologic findings include papillomatosis, hyperkeratosis, variable acanthosis, follicular plugging, and sparse dermal inflammation.<sup>1,3</sup>

### Antibiotics usually clear this rash

Systemic antibiotics, most commonly minocycline 100 mg twice daily for 30 days or doxycycline 100 mg twice daily for 30 days, are safe and effective for CRP.<sup>1,5</sup> Sometimes treatment is extended for as long as 6 months. Although CRP usually responds to minocycline or doxycycline, it is believed that this is the result of these drugs' anti-inflammatory—rather than antibiotic—properties.<sup>1,2,5</sup> Azithromycin is an effective alternative therapy.<sup>2,5</sup>

There is a high rate of recurrence of CRP in patients after systemic antibiotics are discontinued.<sup>2</sup> Uniform responses to treatment and retreatment of flares have solidified the belief that antibiotics are an effective suppressive if not curative therapy, despite a lack of randomized controlled trials.<sup>5</sup>

■ **Our patient** was treated with minocycline 100 mg BID. After 1 month, the rash had improved by 70%. In 3 months it was completely clear and the treatment was discontinued. **JFP**

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