

Dermato-venereological Quiz

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History and examination

An 8-year-old Chinese boy presented with a skin eruption for two years. The eruptions were itchy and ran a relapsing and remitting course mainly affecting the trunk and limbs. The boy had good past health. He was otherwise well with no systemic symptoms and he had no history of medication intake. Physical examination revealed some small erythematous plaques with a fine collarette of adherent scale, erythematous papules with or without scabs and some post-inflammatory



Figure 1.

hypopigmentation scattered on the trunk and limbs (Figures 1 & 2). The head and neck area were spared. There was no hepatosplenomegaly or lymphadenopathy.



Figure 2.

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Questions

- 1) What are the clinical differential diagnoses?
- 2) What are the investigations required?
- 3) What is the most likely diagnosis?
- 4) What are the treatment options?

(Answers on page 50)

Answers to Dermato-venereological Quiz on page 41

1. The differential diagnoses include pityriasis lichenoides (PL), pityriasis rosea, guttate psoriasis, lichen planus, lymphomatoid papulosis and Gianotti-Crosti syndrome.
2. A normal laboratory test profile is expected in all patients although erythrocyte sedimentation rate and C-reactive protein may be raised. A skin biopsy to rule out other differentials, in particular lymphoproliferative diseases, when the clinical presentation is atypical.
3. Pityriasis lichenoides chronica (PLC). This is an uncommon lymphoproliferative dermatosis of unknown aetiology. A lymphocytic reaction to a presumed viral antigen was proposed. It has a clinical and pathological spectrum ranging from acute to chronic eruptions: pityriasis lichenoides et varioliformis acuta (PLEVA) and PLC. A very rare febrile ulceronecrotic variant has also been reported. PLEVA typically presents with acute onset of erythematous papular eruptions on the trunk and proximal extremities that evolve to become pseudo-vesicular, haemorrhagic or necrotic lesions. Pityriasis lichenoides chronica presents with recurrent crops of small erythematous polymorphic scaling plaques that resolve spontaneously with residual post-inflammatory pigmentary changes. Pityriasis lichenoides mostly occurs in the first decade (but rarely before two years) with a slight prevalence in males. The relationship between PL, lymphomatoid papulosis and lymphoma is controversial and a skin biopsy is definitely helpful to distinguish these conditions. The majority of cases run a benign self-resolving course. The key to diagnosis is the typical age group with typical recurrent crops of polymorphic eruptions.
4. Neither specific treatment nor controlled trials are available. The fact that PL tends to resolve spontaneously over months or years makes observation a reasonable option. Topical steroids and longer course of oral erythromycin have been reported mostly in paediatric case series.¹ Other beneficial options frequently reported are phototherapy with UVA, UVA-1, narrowband UVB and UVA plus Psoralen. Exposure to natural sunlight is another option for young children in whom phototherapy is difficult to perform and the long-term risk of skin cancer is of concern.

Reference

1. Ersoy-Evans S, Greco MF, Mancini AJ, Subasi N, Paller AS. Pityriasis lichenoides in childhood: a retrospective review of 124 patients. *J Am Acad Dermatol* 2007;56:205-10.