DERMATO-VENEREOLOGICAL QUIZ

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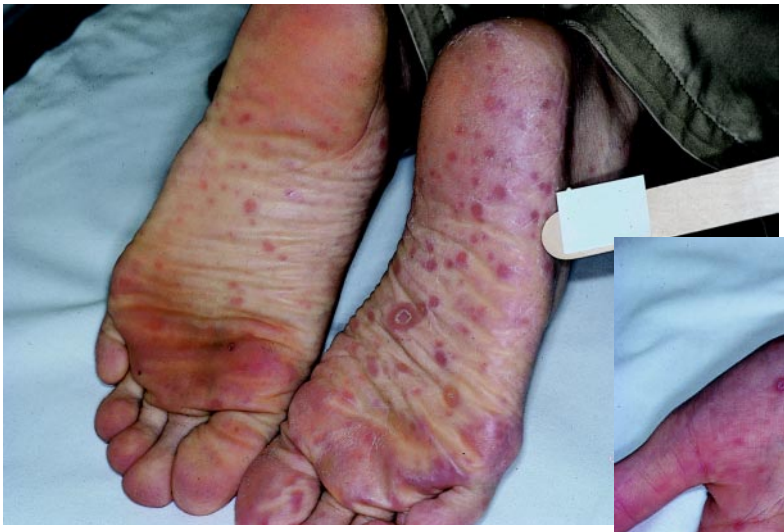
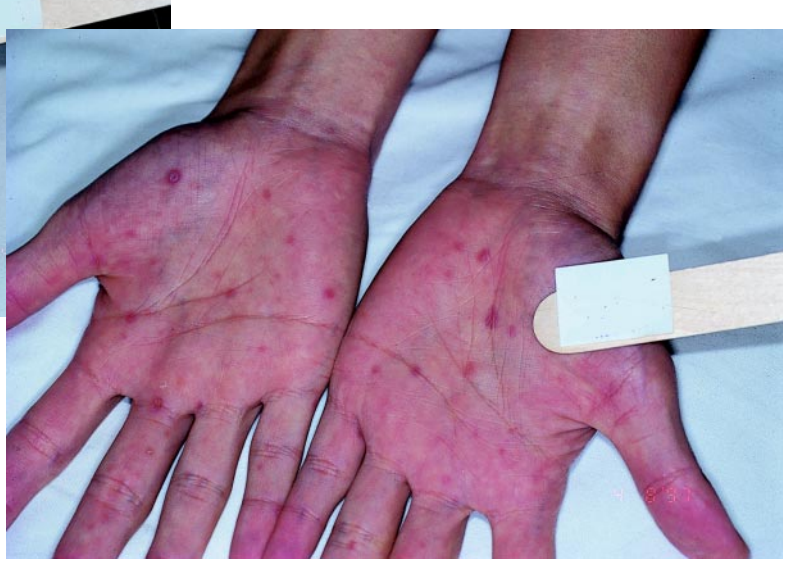




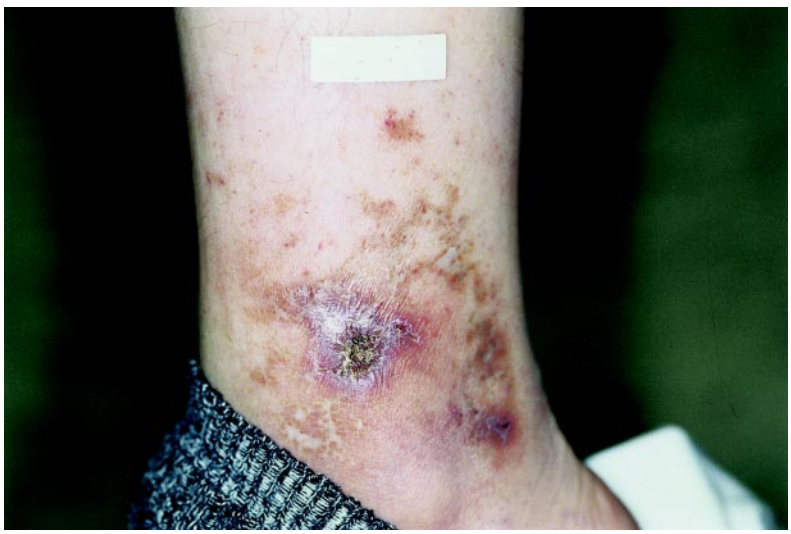
Question 1

This man presented with non-pruritic symmetrical papulosquamous eruptions of the trunk, palms and soles for 2 weeks. He did not notice any genital ulceration. His wife was in China and he denied any extramarital sex.

1. *What are the differential diagnoses?*
2. *Which is the most likely diagnosis and what other manifestations may be present to support the diagnosis?*
3. *Can you suggest an investigation that may enhance a quick diagnosis in this patient?*

Question 2

This young lady had recurrent, painful ulcerations on both ankles. On examination, there was an atrophic porcelain-white macule with central, scabbed ulcer. Reticular streaks of hyperpigmentation, purpura and stellate scarring were seen on the surrounding area.



1. *What is the morphological term of the lesion?*
2. *What can be the causes and how can we make the diagnosis?*
3. *The investigations could not show any evidence of vasculitis or underlying diseases. How should the patient be managed?*

Answers (Question 1)

1. The differential diagnoses include secondary syphilis, guttate psoriasis, generalized drug eruption and tinea infection.

2. The most likely diagnosis is secondary syphilis and other manifestations include mucous patches, mucosal snail tract ulcers, moth-eaten alopecia, condylomata lata, fever, and generalized lymphadenopathy.

3. One can scrape the skin lesion until it oozes, then collect the serum for spirochete demonstration under dark ground microscopy.

Answers (Question 2)

1. Atrophie blanche

2. The lesions can be primary idiopathic (livedoid vasculopathy) or secondary to underlying collagen vascular diseases, hypertensive or diabetic vasculopathy, dysproteinaemic states or venous stasis. Blood tests should include complete blood picture, autoimmune markers and antiphospholipid antibodies to exclude hypercoagulable/ hyperviscosity states, connective tissue diseases and vasculitis. Skin biopsy can help to diffentiate livedoid vasculopathy from vasculitis.

3. The patient should have bed rest, frequent leg elevation and ulcer care to prevent secondary infection. In livedoid vasculopathy, an idiopathic microcirculatory-occlusive disease, various antiplatelet therapies, anticoagulant and fibrinolytic including aspirin, dipyridamole, ticlopidine, pentoxifylline, phenformin, ethylestrenol, and tissue plasminogen activator are reported to be useful.