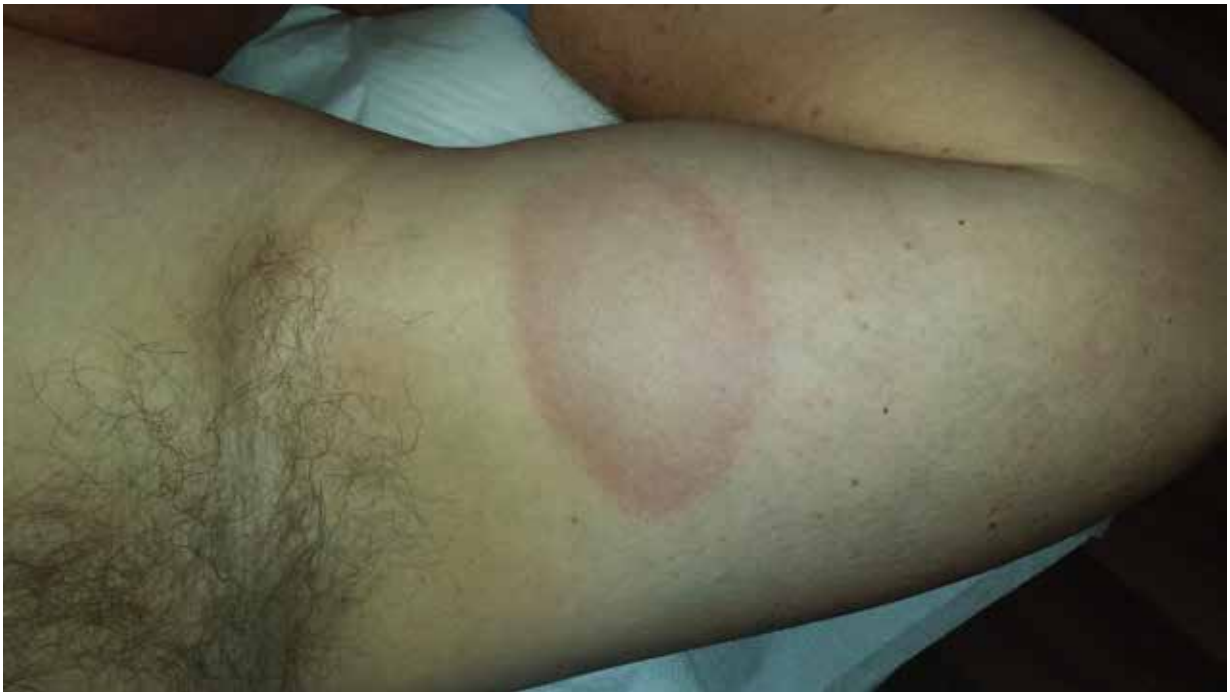
If at First You Don't Succeed … Don't Just Treat Again



A 39-year-old man presents with asymptomatic lesions on both arms. When they manifested about six months ago, the patient diagnosed himself with "ringworm" and began treating them with an OTC clotrimazole cream his pharmacist recommended. Twice-daily application for two weeks did not result in a change, so the patient consulted his primary care provider (PCP), who also thought the problem was fungal. The PCP prescribed oral terbinafine (250 mg/d), which the patient took for a month without improvement. He then requested a referral to dermatology.

Joe R. Monroe, MPAS, PA, practices at Dawkins Dermatology Clinic in Oklahoma City. He is also the founder of the Society of Dermatology Physician Assistants.

The patient denies fever, malaise, shortness of breath, or unexplained weight loss. He is not taking any prescription medications.

Both medial triceps have almost identical lesions: brownish red and oval, with well-defined margins. The margins are slightly raised relative to the central portions. The lesions, which measure 8 x 10 cm, exhibit no epidermal changes (eg, scale or papularity); they are totally intradermal.

The rest of the examination is unremarkable.

What is the best "next step"?

a) Try a different antifungal medication (eg, oral itraconazole)

b) Try a combination cream (eg, clotrimazole/betamethasone)

c) Refer the patient for consideration of laser treatment

d) Perform a punch biopsy to clarify the diagnosis

ANSWER

Punch biopsy (choice "d") is the correct answer for one simple reason: Correct diagnosis dictates correct treatment. What we're missing is a diagnosis we can rely on.

DISCUSSION

This case demonstrates a major difference in outlook between the generalist and the specialist. The former is more interested in treating the problem, while the latter first wants to know what

continued on page 26 >>

>> *continued from page 21*

the problem is, then tailors the treatment to that problem and/or reassures the patient of the problem's benign nature.

Had these lesions been of fungal origin, terbinafine would have had a positive effect. Furthermore, fungal infections are caused by organisms that only affect the outer layer of skin and create scaling, which was notably missing in this case.

Round to oval lesions suggest a number of diagnostic possibilities, only one of which is fungal (dermatophytosis). Others include T-cell lymphoma, psoriasis (though its lesions are almost always scaly), sarcoidosis, Hansen disease, lupus, and lichen planus. In cases like this one, these options need to be sorted through—and the only sure way to do that is with biopsy.

This patient's biopsy showed a palisaded granulomatous process consistent with granuloma annulare (GA), a very commonly diagnosed benign condition. Since there are no ideal treatments for GA, he opted to do nothing, although he agreed to present for a biannual check-up. He was happy just to rule out all the things he *didn't* have and thereby reduce his worries. **CR**