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The Clinical Picture

A young person with papules and plaques

Q: A HEALTHY 22-YEAR-OLD graduate student developed somewhat pruritic, finely scaling papules and plaques on the trunk, arms, and thighs (FIGURE 1). The biggest plaque, on the chest, was the first to appear.

What is the most likely diagnosis?

- ❑ Psoriasis
- ❑ Pityriasis (tinea) versicolor
- ❑ Pityriasis rosea
- ❑ Molluscum contagiosum
- ❑ Erythema multiforme

A: The correct answer is pityriasis rosea.

Psoriasis typically exhibits sharply demarcated salmon-pink papules and plaques with adherent silvery white scale on the elbows, knees, and scalp. Nail dystrophy occurs in 50% of affected patients.

Pityriasis (tinea) versicolor, caused by the yeast *Pityrosporum ovale* (*Malassezia furfur*), is an asymptomatic disease consisting of fine, well-demarcated, discrete, and confluent scaly plaques with variable pigmentation. Disease primarily affects the trunk and proximal extremities.

Molluscum contagiosum is an epidermal viral infection consisting of flesh-colored, often umbilicated, papules caused by the DNA pox virus.

Erythema multiforme, commonly associated with constitutional symptoms, is an acute hypersensitivity reaction of macules, plaques, vesicles, and bullae, often with a targetoid or iris-shaped appearance. This usually affects the extremities and trunk and occasionally affects the mucous membranes (Stevens-Johnson syndrome).

Manifestations of pityriasis rosea

Pityriasis rosea is an acute inflammatory skin disease that typically affects healthy young adults in spring and autumn. A herald ("mother") patch—a single erythematous oval plaque, with a collarette scale, on the trunk, arm, or leg—signals the onset of disease, and is followed by other smaller but similar plaques on the trunk and proximal extremities. Established disease often mimics a "Christmas tree" distribution on the trunk. The palms, soles, and face are usually spared. The disease evolves over 2 to 3 weeks and may last 6 to 12 weeks. Itching is usually negligible or absent.

FIGURE 1

Establishing the diagnosis

The clinical appearance, morphology, and distribution of the patches and plaques establish the diagnosis. Skin biopsy is usually not necessary. The differential diagnosis may include secondary syphilis, drug eruption, viral exanthem, and eczema. Pityriasis rosea can be distinguished from psoriasis in that the latter is a chronic inflammatory skin disorder. For atypical presentations, such as those that persist longer than 3 months or involve the face, palms, or soles, a biopsy and Venereal Disease Research Laboratory (VDRL) test are warranted. The etiology is unclear, although some studies suggest a viral origin, specifically human herpesvirus-7. No systemic disease associations have been reported.

Treatment

For most patients, treatment is symptomatic, coupled with reassurance and education. Some require therapy with a topical corticosteroid, antihistamines, or emollients to relieve the mild pruritus. There is little need for systemic corticosteroids or other measures, such as ultraviolet B light therapy. The disease remits spontaneously, and recurrence is rare (1% to 2%).

SUGGESTED READING

Hartley AH. Pityriasis rosea. Ped Rev 1999; 20:266–269.