Palmar initial lesion in pityriasisrosea

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Abstract

Pityriasisrosea is a frequently encountered skin disease associated with typical erythematous-squamous lesions. Majority of the cases relate to patients between 10 and 35 years of age. In clinically typical cases, the disease appears with the initial lesion called herald patch. The initial lesion generally locates on trunk, neck and proximal extremities. However, it can rarely be seen on other body parts such as face, scalp, and genital region. The initial lesion located on palmar region has been just once presented in literature. In this study, we present a 22-year-old female patient with palmar initial lesion who was followed up with misdiagnosis until rashes appeared on her body.

Keywords: Pityriasisrosea, Herald patch, Palmar.

Introduction

Pityriasisrosea (PR) is an inflammatory skin disease of unknown origin characterised with typical erythematous-squamous lesions.[1] Its prevalence among the skin diseases has been accepted as 1%.[1] It typically affects children and young adults more.[2] Due to its conspicuous appearance, the patients are anxious, and therefore, they consult a doctor.

Its aetiology has not been known exactly, and especially some viral infections are blamed.[1] Some characteristics of the disease such as the monomorphic characterisations of lesions, seasonal inflammations, observing some prodromal indications, its starting with initial lesion evoking the primary inoculation, almost no recurrence of the disease and spontaneous recovery have all supported the view of viral infection in aetiology. However, no antiviral antibodies against the virus and the virus itself could be determined.[1] Moreover, after the use of some medications, PR or PR-like rashes were identified.[1] It was understood that there are some unclear points even in viral infections and medication which emphasises on finding the aetiology of PR.

The disease mostly begins with mild prodromal symptoms such as inconspicuous headache, fever, arthralgia and fatigue.[1] The first skin sign is an erythematous-squamous lesion, oval or round shaped located most frequently on the trunk called the herald patch. Although herald patch primarily is located on the trunk and distal of extremities, it can rarely be seen on other body parts such as face, scalp, and genital region.[3] The initial lesion located on palmar region has been presented in literature just once.[4] In this study, we present the case of a 22-year-old female patient with palmar initial lesion who was misdiagnosed until rashes appeared on her body.

Case Report

A 22-year-old female patient presented to our clinic with complaint of rash on her trunk and arms. When patient's history was explored, it revealed that an asymptomatic oval-shaped lesion had appeared on the palmar region of her hand 10 days earlier before the rashers started to appear on her body. On a diagnosis of 'Tineamanum' local antifungal treatment was administered to the patient by her family physician. However, since the lesion did not go away and new lesions appeared on the body during the follow-up

Figure-1: Palmar herald patch.

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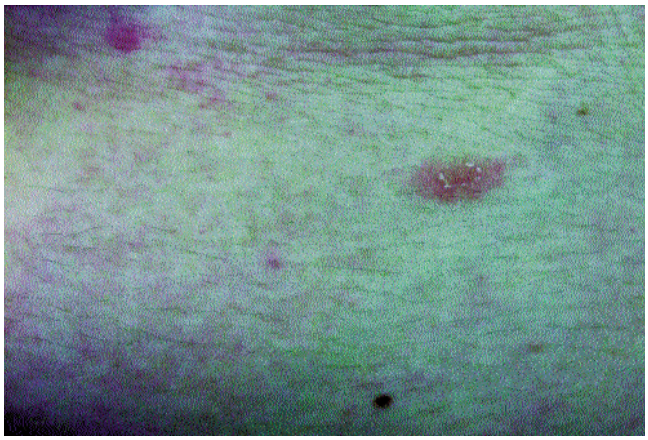

Figure-2: Erythematous patches with fine collarette scales on the trunk.

period, she was referred to our clinic.

On dermatological examination, erythematous patch with fine collaret scales that covered about 5cm area was seen on the palmar aspect of the right hand (Figure-1). In addition, smaller and more erythematous multiple lesions than the palmar lesion were identified in upper extremities, trunk and thighs (Figure-2). The patient's physical examination was normal except for the rashes. Questions related to the aetiology of the disease, such as medication history, infection history, revealed no pathology. The routine laboratory analysis and investigations (such as venereal disease research laboratory [VDRL]), gave no abnormal results. PR was clinically diagnosed. The patient was successfully treated with local topical steroid and oral antihistaminics, and all lesions completely regressed within a month.

Discussion

PR is a frequently encountered skin eruption limiting itself and accompanied by typical erythematous-squamous lesions.[1] The disease mostly begins with mild prodromal symptoms that cannot be exactly noticed.[5] The first skin symptom is a pink or salmon pink, oval or round-shaped, sharply circumscribed, erythematous-squamous initial lesion called the herald patch.[1,5] Its diameter frequently varies between 2cm and 4cm, but these can also be on a plate less than 1cm or as big as 10cm.[5] Moreover, this lesion is also called as the main plate, or medallion plate, and has mild wrinkled or healthy skin appearance; there are small and fine squamas on the lesion. In peripheral parts of the lesion, bigger, more apparent, free collaret style squamas are observed. The incidence of the initial lesion varies between 12% and 94% according to some studies; however, it was noticed in 50% of the cases according to the majority of series.[5] Nearly 7-14 days subsequent to the initial lesion, a common bilateral skin rash with symmetric appearance and localised to the trunk develops. In contrast to the initial lesion, these lesions with great number are smaller and like the miniature of the initial plate.[1,5]

It can be hard to diagnose PR until characteristic small secondary lesions appear. When the initial lesion does not primarily locate on the expected body areas, it can cause more confusion. Although initial lesion primarily locates on the trunk and distal parts of extremities, but it can rarely locate on other body parts such as face, scalp and genital area.[3] During this window period before the secondary lesions appear, several various diagnoses can be established for the initial lesion, like tinea, eczema, drug eruption, viral eruptions, and syphilis.[1,5] In secondary syphilis, the lesions more similar to PR can be noticed. For that reason, it is suggested to perform a serologic test for syphilis in each PR patient.[5] The drugs are blamed in PR aetiology, and mentioned to cause PR-like lesions. Great numbers of medications such as arsenic, ketotifen, omeprozol, terbinafine, barbiturates, golden, isotretinoine, metronidazole, captopril, interferon alpha, D-penicilamine have all been blamed.[1,5] Like drugs, viral infections have also been included into the differential diagnosis and aetiology of PR. In recent years, most attention has been drawn to the fact that Human herpesvirus 6 (HHV-6) and HHV-7 can be responsible for the aetiology. However, although virus-like particles were presented electro-microscopically, the virus itself or antiviral antibodies could not be determined.[1]

Because PR is asymptomatic and self-limiting, informing the patient and overcoming the worries can be adequate for treatment.[1,5] The complaint of rash varying in range between mild to severe was reported in nearly 25% of the patients.[5] It has had no specific treatment method. However, it is important to avoid applications traumatizing the lesions. Oral antihistaminic treatment can be administered to itchy cases. Topically, mild-mid-effect corticosteroids can be preferred. In more severe cases, ultraviolet-B (UVB) treatment or natural sun-ray bathing can be preferred. In rare cases, short-term systemic corticosteroid treatment can be needed.[5] In a double-blind, placebo controlled study, after erythromycin uptake in doses divided into 14 days, full regression was experienced in 73% of the patients. No regression was noticed in the placebo group during the same period.[6]

Conclusion

Palmar herald patch has been presented in literature just once, while plantar herald patch has also been reported in one case. The case here adds to the literature related to PR on palmar region during the window period when no secondary lesions were noticed.

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