Erythema Multiforme and Pityriasis Rosea

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A Photo Quiz to Hone Dermatologic Skills

Case 1:
For 5 days, a 38-year-old man has been bothered by a mildly pruritic and slightly tender rash on the trunk, legs, arms, and hands. He has no history of similar episodes. The patient recently completed a 5-day course of an antiviral agent he has used before to treat recurrent herpes labialis. He takes no other medications.

Do you recognize this eruption?

A. Disseminated herpes simplex.
B. A fixed drug eruption.
C. A maculopapular drug eruption.
D. Erythema multiforme.
E. Psoriasis.

(Answer on next page.)

Case 1: Erythema multiforme
The occurrence of "target" lesions with a vesicular center following a herpes simplex virus infection and involvement of the palms is a classic presentation of erythema multiforme, D. A skin biopsy can help confirm the diagnosis. This self-limited eruption ran the typical benign course and resolved in 3 weeks.

Disseminated herpes simplex does not usually affect an immunocompetent host. Unlike the rash in this patient, a fixed drug eruption presents initially with a single lesion. Adverse drug reactions to antiviral therapy are very rare; even when a skin biopsy is performed, it is difficult to distinguish such reactions from erythema multiforme. However, if desired, a drug rechallenge may be tried to confirm an adverse reaction. The vesiculation and target lesions on the palms in this patient are not characteristic of psoriasis, which features scaly, more pruritic lesions.
The parents of a 9-year-old girl are concerned about their daughter's rash that developed 1 week earlier. The asymptomatic eruption is primarily on the trunk. The patient has no history of contactant exposure, takes no medications, and has not had any recent illnesses. The family pets include a dog and a cat.

**What is the most likely cause of this patient's rash?**

A. Pityriasis rosea.
B. Psoriasis.
C. Tinea corporis.
D. Nummular eczema.
E. Contact dermatitis.

*(Answer on next page.)*

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**Case 2: Pityriasis rosea**

Circular patches of scaling and erythema are clues to pityriasis rosea, A, a self-limited disease that may last for weeks to months. This patient exhibits signs of both the common form of the disorder and a papular variant. A corticosteroid cream and the anti-inflammatory effect of moderate exposure to sunlight cleared the outbreak.

Psoriasis in this age group usually follows a streptococcal infection; this patient had no such history. Her rash was far too extensive to be tinea corporis. She had no history of atopy, which made nummular eczema unlikely. Contact dermatitis is pruritic and not as discrete as this patient's lesions.

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**Case 3:**

For a few months, a 47-year-old man has had a persistent, asymptomatic patch on his upper arm. The patient has no significant medical problems, takes no medications, and has no history of seasonal allergies. He keeps a pet cat and enjoys gardening.

**What do you suspect?**

A. Nummular eczema.
B. Basal cell carcinoma.
C. Actinic keratosis.
D. Pityriasis rosea.
E. Tinea corporis.

*(Answer on next page.)*
**Case 3: Basal cell carcinoma**
A skin biopsy confirmed the clinical suspicion of basal cell carcinoma, B. Because the patient worked shirtless every summer in his garden, actinic keratosis was a diagnostic consideration. The basal cell carcinoma was excised completely, and the patient was instructed to use sunscreen when exposure to the sun could not be avoided. This asymptomatic lesion was neither pruritic nor scaly, thus ruling out nummular eczema and pityriasis rosea, respectively. Fungal infections generally are scaly and often pruritic; although they expand slowly, they do so more quickly than basal cell carcinoma.

**Case 4:**
The parents of an 8-year-old boy seek evaluation of a red patch on their son’s shoulder. The asymptomatic spot erupted 2 weeks earlier. The patient has seasonal allergies and frequently plays with his dog.

**What is your clinical impression?**

A. Psoriasis.
B. Tinea corporis.
C. Impetigo.
D. Contact dermatitis.
E. Erythema migrans.

*(Answer on next page.)*

**Case 4: Tinea corporis**
A potassium hydroxide evaluation confirmed tinea corporis, B, which responded to a topical antifungal. The family was advised to have their dog examined by a veterinarian because the pet was the suspected source of the dermatophyte.

Erythema migrans associated with Lyme disease was unlikely, since the patient had no prodromal symptoms and the lesion developed in winter, long after the tick bite transmission season. Because the single lesion was not pruritic and erupted on a site that was covered by clothing, patch tests for contact dermatitis were not warranted. The lesion demonstrated far less scale than is seen in psoriasis; the absence of tender, crusted vesicles ruled out impetigo.
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