A pruritic facial eruption; asymptomatic, erythematous lesions; a persistent papule--can you identify the disorders pictured here?

Case 1:
This pruritic eruption on the face of a 56-year-old man has been worsening for 3 months. Treatment with topical metronidazole was ineffective.

What is your clinical suspicion?
A. Tinea faciei.
B. Pseudofolliculitis barbae.
C. Shaving folliculitis.
D. Acne.
E. Pityrosporum folliculitis.
(Answer on next page.)

Case 1: A potassium hydroxide evaluation confirmed the diagnosis of tinea faciei, A. This patient was a farmer, and the infection was attributed to occupational exposure. He was successfully treated with oral and topical antifungal antibiotics. Pseudofolliculitis barbae and shaving folliculitis usually cover a more extensive area. Acne lesions would not last 3 months. Pityrosporum folliculitis does not occur on the face.
Case 2:
A 38-year-old woman has had a "pimple" on her nose for at least 3 months. She is otherwise healthy. What does this look like to you?
A. Sebaceous hyperplasia.
B. Fibrous papule.
C. Basal cell carcinoma.
D. Wart.
E. Acne.
(Answer on next page.)

Case 2: A biopsy confirmed the diagnosis of basal cell carcinoma, C. Acnelike lesions that last longer than 2 months require investigation. A pearly surface and telangiectasia may suggest basal cell carcinoma; however, sebaceous hyperplasia, fibrous papules of the nose, and warts may all mimic this malignancy, and a biopsy is required for a definitive diagnosis. Acne lesions do not last for more than 2 months unless the patient is manipulating them.

Case 3:
For several months, a 12-year-old girl has had asymptomatic erythematous papules on the sides of her nose. She is otherwise healthy. Which condition is responsible for the eruption?
A. Acne.
B. Keratosis pilaris.
C. Staphylococcal infection.
D. Candidal infection.
E. Seborrheic dermatitis.
(Answer on next page.)

Case 3: The patient had a papular variant of seborrheic dermatitis, E, that is common in
preteenagers. This is generally a clinical diagnosis based on the appearance and location of the lesions. The dermatitis responded to a sulfacetamide/sulfur topical antibiotic. An antifungal cream is another treatment option.

Acne is not typically confined to the paranasal region. Keratosis pilaris typically is found in the mid-cheek area. Staphylococcal and candidal infections are more inflammatory and symptomatic.

**Case 4:**
A 17-year-old girl seeks treatment of acne that has resisted oral and topical antibiotics. The eruptions tend to occur when she menstruates. She is otherwise healthy and takes no medications.

What do you suspect?
A. Stress-induced acne.
B. *Pityrosporum* acne.
C. Polycystic ovarian disease.
D. Acne cosmetica.
E. Antibiotic-resistant acne.

*(Answer on next page.)*

**Case 4:** The presence of unwanted facial hair (extended sideburns) and the occurrence of acne flares during menstruation suggested **polycystic ovarian disease, C**, which was confirmed by ultrasonography. The patient was successfully treated with oral contraceptives.

Stress-induced acne has the same jawline pattern as the acne associated with polycystic ovarian disease, but it flares with stress rather than with the menstrual cycle. *Pityrosporum* acne is usually pruritic and tends not to occur on the face. Cosmetics are less comedogenic than in previous years and thus are less likely to exacerbate acne.

Antibiotic resistance is a major concern in the treatment of acne. A high prevalence of resistance to erythromycin (more than 60%), as well as to the tetracyclines and clindamycin, has been observed in the general population.¹

**References:**

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