An Erythematous-squamous Lesion of the Foot: A Quiz

Stefano VERALDI, Paolo PONTINI and Gianluca NAZZARO
Department of Pathophysiology and Transplantation, Università degli Studi di Milano, IRCCS Foundation, Cà Granda Ospedale Maggiore Policlinico, Milan, Italy. E-mail: stefano.veraldi@unimi.it

A 23-year-old Caucasian man presented with an inflammatory lesion on his right foot. The patient reported that he was in good general health and not on any systemic drug therapy. The lesion had appeared one week earlier accompanied by mild pruritus. No treatment was given prior to our examination. The latter showed an oval, 3×2 cm lesion on the medial surface of the right foot. The lesion was characterized by fine desquamation in the centre and well-defined, erythematous-papular borders (Fig. 1). No similar lesions were observed elsewhere.

A clinical diagnosis of tinea was made. However, mycological examinations were negative. Bacteriological examinations were also negative. All laboratory tests, including tests for syphilis, were negative or within normal ranges. A biopsy was suggested, but was refused by the patient due to his work as a footballer. He was discharged without therapy. One week later, the patient returned due to development of an erythematous-papular, mildly pruritic rash on his trunk, upper limbs and thighs.

What is your diagnosis? See next page for answer.

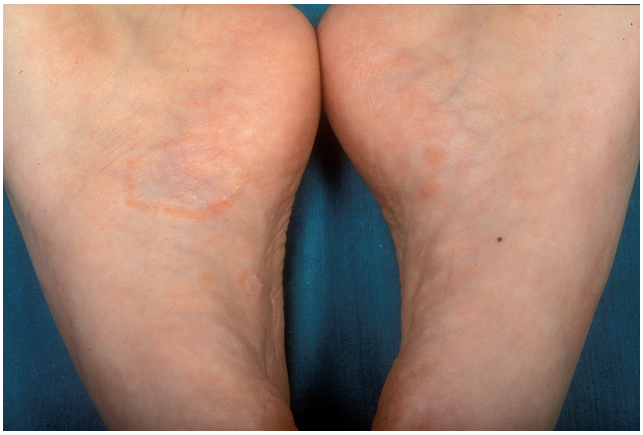

Fig. 1. Erythematous-squamous lesion on the foot.

doi: 10.2340/00015555-2892
Acta Derm Venereol 2018; 98: 813–814

ANSWERS TO QUIZ

An Erythematous-squamous Lesion on the Foot: A Commentary

Acta Derm Venereol 2018; 98: 813–814.

Diagnosis: **Herald patch of pityriasis rosea**

The clinical presentation of the rash was typical of pityriasis rosea (PR). The patient was treated with cetirizine (10 mg/day for 10 days). No topical treatment was prescribed. Complete remission of the rash was observed within 4 weeks.

According to the literature and our personal clinical experience, it is unusual for PR to involve the hands and feet. However, the involvement of hands and feet in African patients is common (1). Furthermore, in a French study of 249 patients with PR, 4% had palmoplantar involvement (2). Involvement of the feet is clinically polymorphous: hyperkeratotic macules (3), scaly erythematous patches or plaques (4, 5), desquamation (6), vesicles (4, 7, 8) and blisters (9) have been reported. To our knowledge, only one case of (rather atypical) herald patch of PR on the feet has been reported previously (10).

REFERENCES

1. Vollum DI. Pityriasis rosea in the African. Trans St Johns Hosp Dermatol Soc 1973; 59: 269–271.
2. Will F, Dallara JM, Dimov E, Farque JF, Galliath C, Garnier C, et al. Le pityriasis rosé de Gibert en l'an 2000. Etude épidémiologique Alsaderm. Nouv Dermatol 2001; 20: 167–168.
3. Offidani A, Cellini A. Pityriasis rosé de Gibert touchant les pieds. Ann Dermatol Venereol 1998; 125: 608.
4. Deng Y, Li H, Chen X. Palmoplantar pityriasis rosea: two case reports. J Eur Acad Derm Venereol 2007; 21: 406–407.
5. Bukhari I. Pityriasis rosea with palmoplantar plaque psoriasis. Dermatol Online J 2005; 11: 27.
6. Eslick GD. Atypical pityriasis rosea or psoriasis guttata? Early examination is the key to a correct diagnosis. Int J Dermatol 2002; 41: 788–791.
7. Garcia RL. Vesicular pityriasis rosea. Arch Dermatol 1976; 112: 410.
8. Miranda SB, Lupi O, Lucas E. Vesicular pityriasis rosea: response to erythromycin treatment. J Eur Acad Derm Venereol 2004; 18: 622–625.
9. Samsoën M, Kern C. Pityriasis rosé et anticorps antirubéole. Nouv Dermatol 2003; 22: 40.
10. Robati RM, Toossi P. Plantar herald patch in pityriasis rosea. Clin Exp Dermatol 2009; 34: 269–270.