

Atypical Pityriasis Rosea with a Target-Shape Herald Patch

Abstract

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Received: Janaury 8, 2010
Accepted: Februaery 25,2010

Pityriasis rosea (PR) is an acute, self-limiting papulosquamous exanthem. A number of atypical variants of PR, regarding morphology and distribution of the lesions or severity of the symptoms, may be observed. Herein, we present the first case of atypical PR with hypopigmented lesions and a target-shape herald patch. (*Iran J Dermatol* 2010;13:24-26)

Key words: pityriasis rosea, atypical pityriasis rosea, herald patch, target shape

Introduction

Pityriasis rosea (PR) is an acute, self-limiting exanthem characterized by oval erythematous-squamous lesions of the trunk and limbs usually sparing face, scalp, palms, and soles¹. Classically, pityriasis rosea begins as an erythematous, scaly patch on the trunk, known as a herald patch. The herald patch is usually several centimeters in diameter, compared with the typical 1 cm lesions in generalized pityriasis rosea. In several days or weeks after the onset of the herald patch, widespread typical pink macules and papules with fine scales appear. These are bilateral and symmetrical oval shape lesions, classically arranged with their long axes parallel to lines of cleavage, resulting in the characteristic "Christmas Tree" distribution.² To date, many atypical variants of PR have been described³ such as inverse PR⁴, unilateral PR⁵, palmoplantar PR⁶, purpuric PR^{7,8}, and vesicular PR^{9,10}. Herein, we present a unique atypical type of PR with a target-shape herald patch and hypopigmented lesions.

Case report

A 9-year-old boy presented with a two-week history of generalized asymptomatic hypopigmented lesions mainly on his trunk and arms. Physical examination revealed disseminated hypopigmented macules and patches with fine scales, showing a typical Christmas tree appearance (Figure 1A). We also observed a

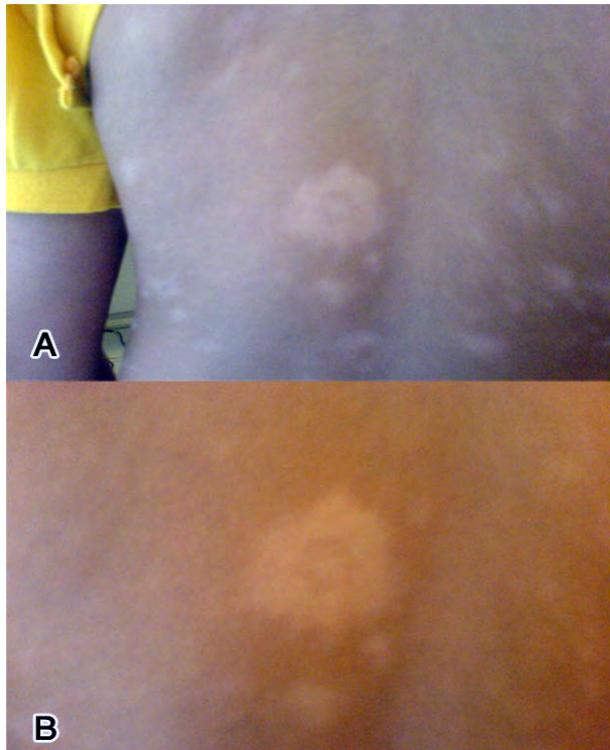


Figure 1. A) Disseminated hypopigmented macules and patches with fine scales, showing the typical Christmas tree appearance. B) A target-shape herald patch with hypopigmented periphery and pigmented center on patient's back.

larger target-shape patch with hypopigmented periphery and a pigmented center on his back

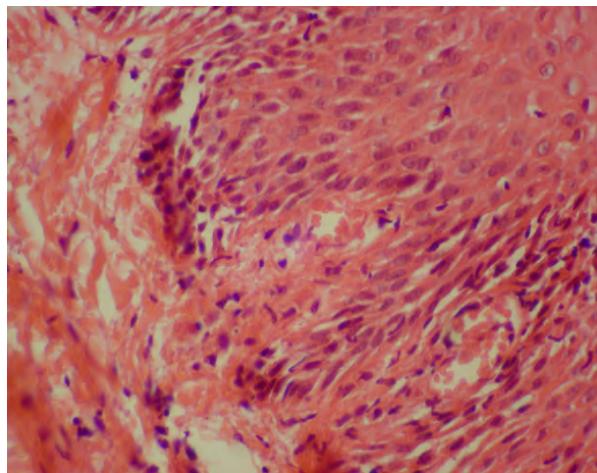


Figure 2. Focal parakeratosis, slight acanthosis, spongiosis, exocytosis with moderate mononuclear perivascular infiltrate in the upper dermis and extravasated RBC. (H&E *40)

(Figure 1B) which had appeared 7 days before other lesions. There was no mucosal involvement. No axillary or inguinal lymphadenopathy was detected. These lesions were not associated with any prodromal symptoms such as fever, headache, malaise or sore throat. His parents denied the use of any prior medication. No family member had similar lesions. Complete blood count, erythrocyte sedimentation rate and urine analysis were all normal. We performed a skin biopsy from a lesion of his trunk. The histological analysis of this biopsy revealed focal parakeratosis, slight acanthosis, spongiosis, exocytosis with moderate mononuclear perivascular infiltrate in the upper dermis and extravasated erythrocytes (Figure 2). The patient was diagnosed with atypical pityriasis rosea and his parents were reassured that the condition was self-limited and did not require any treatment. The lesions resolved completely during 2 months and no recurrence was reported in a 6-month follow-up.

Discussion

Pityriasis rosea (PR) is an acute, self-limiting exanthematous disease characterized by oval erythematous-squamous lesions of the trunk and limbs¹. It is universal and most patients are between the age of 10 and 35 years¹¹. Association of PR with herpes virus 6 and 7 has been proposed although it has remained controversial. Some studies reported a noteworthy presence of upper respiratory tract infection prior to PR in children¹². It has also been hypothesized

that an autoimmune process may underlie the development of pityriasis rosea¹³.

A number of atypical variants of PR may be observed. These forms account for 20% of cases. The morphology of rash may be atypical as vesicular, purpuric or hemorrhagic, and urticarial variants^{7,10}. The distribution of lesions may be atypical; the face, axillae, and groins are predominantly involved in inverse PR. The shoulders and hips are mainly affected in limb-girdle PR¹¹. Involvements of mucous membranes such as the oral cavity and palmoplantar PR have been reported. The severity may also be atypical. Patients with severe pruritus, pain, and a burning sensation can be said to have PR irritate^{11,14}.

In conclusion, our patient had a unique atypical morphology: a target-shape herald patch with hypopigmented macules and patches. To our knowledge, this is the first reported case of atypical PR with such a clinical appearance.

PR is usually self-limited and eventually resolves in 1–3 months; however, topical steroid, UVB phototherapy, oral antihistamines, oral erythromycin, and oral acyclovir can be used in severe or recalcitrant cases^{10,15}.

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