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ΑΡΧΕΙΑ ΕΛΛΗΝΙΚΗΣ ΙΑΤΡΙΚΗΣ 2015, 32(3):375

Clinical Immunology Quiz – Case 7

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A 32-year-old man presented with an abrupt onset of a widespread, intensely pruritic eruption without constitutional symptoms or abnormal laboratory findings, 48 hours after a mildly febrile upper respiratory infection and 24 hours after taking two doses of clarithromycin 500 mg (bid). The rash appeared initially on the trunk as numerous asymptomatic small subtle erythematous to brown papules, which gradually spread centrifugally to the extremities and neck but sparing the head (fig. 1). The papules developed into polymorphic reddish plaques with a centrally adherent micaceous, crusted scale (fig. 1, detail) which could be detached easily to reveal a shiny pinkish surface within a few days. They flattened spontaneously and faded over a period of 3 to 4 weeks, leaving a superficial residual excoriation. The lesions were present in all stages of development during the acute stage of the illness. Laboratory studies were unremarkable. The histopathology revealed focal parakeratosis and spongiosis, as well as moderate acanthosis in the epidermis, mild superficial perivascular lymphohistiocytic infiltrate with occasional extravasated erythrocytes in the dermis and no sign of vasculitis.

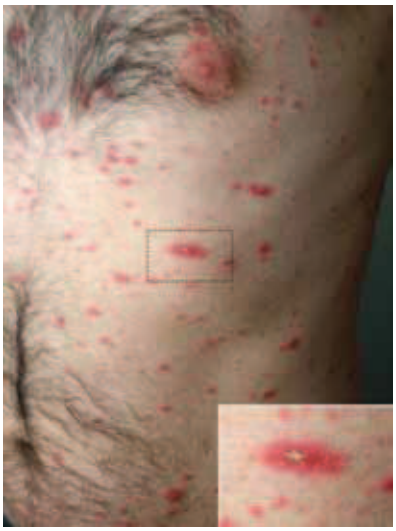

Figure 1

Questions

a. Which is the differential diagnosis of this skin eruption?
b. Could it be a drug hypersensitivity reaction?

Comment

Pityriasis lichenoides chronica (PLC) is a type of idiopathic papulosquamous and self-limited dermatoses of unknown etiology. The diagnosis is made clinicopathologically. The differential diagnosis is wide, including pityriasis lichenoides et varioliformis acuta (PLEVA) drug or viral exanthemas (varicella, herpes simplex virus), guttate psoriasis, pityriasis rosea, lymphomatoid papulosis, secondary syphilis, lichen planus, papular eczematous dermatitis, tinea versicolor, Gianotti-Crosti syndrome and Langerhans cell histiocytosis. In the above case, topical corticosteroids were applied for two weeks and the entire course of the eruption lasted for 11 weeks. The antibiotic was immediately discontinued, but later on the patient was tested negative in allergy skin testing and passed an oral challenge to clarithromycin. In many cases PLC appears after a mild viral infection in patients taking antibiotics and therefore it might be confused with drug hypersensitivity reactions. The clinical course of the exanthema and the histopathology helps in the final diagnosis. Because PLC is a benign, usually self-limited disorder, clinical follow-up without pharmacologic treatment is an option for the management of children and adults with limited, non-scarring, asymptomatic disease. However, patients with persistent extensive and symptomatic or scarring exanthem may often require treatment. First-line therapies include systemic antibiotics (tetracycline, doxycycline, minocycline, or erythromycin), topical corticosteroids and phototherapy.

References

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Diagnosis: *Pityriasis lichenoides chronica*