

Persistent and Generalized Purpuric Lesions in an Adolescent: A Rare Atypical Form of Pityriasis Rosea

Sir,

Pityriasis rosea is an acute inflammatory skin disease characterized by erythematous scaling macules, papules, and plaques predominantly on the trunk and proximal extremities. It has been suggested that viral infections, including human herpes virus 6 (HHV6) and HHV7, upper respiratory tract infections, and drugs such as isotretinoin, D-penicillamine and terbinafine may be associated with pityriasis rosea. In addition to its characteristic clinical features, the disease may rarely present with atypical lesions.^[1]

A 14-year-old Caucasian male presented with a progressive, asymptomatic, erythematous rash on the neck, chest, and arms for the last 2 weeks. The lesions first appeared on the chest and then spread to the trunk and arms. Moreover, the patient reported that he had painful sores in the mouth. These ulcers have been occurring every 4 weeks and healed in a few days without any scar formation. Past medical and family history was unremarkable. There was no history of medication for any other illness in the recent past. Dermatological examination revealed erythematous purpuric macules on the chest, neck, arms [Figure 1a and b] and minor aphthous ulcers on the lower lip mucosa. The lesions did not blanch on diascopy. Patch test was negative. Laboratory tests including complete blood count and chemistry panel were all within normal limits. In addition, serum IgG antibodies to Herpes simplex virus type 1 (HSV1) and serum IgM and IgG antibodies to HSV2 were negative. However, serum HSV1 IgM was positive (34.6 U/mL; reference ranges: 0–19.9 U/mL negative and ≥ 30 U/mL positive). Histopathological evaluation revealed epidermal thinning,

decreased granular layer, loss of the rete ridges, marked perivascular and interstitial mononuclear cell infiltrates, edema, and focal extravasation of erythrocytes in the papillary dermis [Figure 2].

Pigmented purpuric dermatoses, vasculitis, and hematologic disorders were considered in the differential diagnosis. Based on the clinical and histopathological findings, the diagnosis of purpuric pityriasis rosea was made. The patient was started on topical methylprednisolone and oral desloratadine therapy. Despite treatment, the skin lesions extended from the chest to the upper back and thighs. Therefore, twice weekly narrowband ultraviolet B phototherapy (250 mJ/cm²) was recommended. However, the patient did not keep follow up appointments.

Atypical forms of pityriasis rosea can present with vesicular, purpuric, hemorrhagic, urticarial, and papular lesions. Pityriasis circinata et marginata is an uncommon form characterized by fewer and larger lesions. Moreover, involvement of intertriginous areas is called pityriasis rosea inversus. There have been reports of patients with hemorrhagic, erosive, or bullous oral lesions. It has been suggested to use the term pityriasis rosea irritata when the skin rash is accompanied by pain and pruritus.^[2]

Purpuric pityriasis rosea is a rare atypical type of pityriasis rosea, which clinically presents with purpuric macules and papules on the trunk and extremities. The disease has a self-limited benign course.^[3] Purpuric pityriasis rosea-like eruption has been described in patients with acute myeloid leukemia. However, there is controversy whether detailed hematological evaluation is necessary in these patients or not.^[4,5]



Figure 1: (a and b) Erythematous purpuric macules on the trunk and left arm

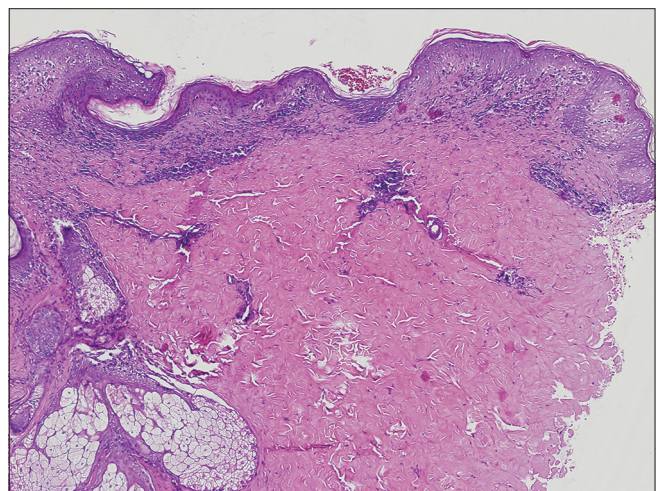


Figure 2: Perivascular and interstitial mononuclear cell infiltrates and focal extravasation of erythrocytes in the papillary dermis (H and E, $\times 40$)

Many viruses including HHV6 and HHV7 have been proposed as causative agents for pityriasis rosea, although there is no conclusive evidence. Here, we presented a case of pityriasis rosea coexisting with oral HSV1 infection. Our case is unique because purpuric pityriasis rosea has not been associated with HSV1 previously. Consequently, we suggest that HSV1 may play role in the etiopathogenesis of the disease, and antiviral therapy may be the treatment of choice for extensive and resistant lesions.

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Conflicts of interest

There are no conflicts of interest.

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