Pityriasis Rosea Unilateralis: A Rare Presentation in Two Females

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Pityriasis rosea (PR) is self-limiting, acute, papulo-squamous disorder characterized by eruption of a herald patch followed by multiple round to oval scaly eruptions typically on the trunk and proximal extremities along lines of cleavage, known as christmas tree appearance[1] Atypical presentation of PR usually poses a diagnostic challenge in OPD.

A 27-year-old female presented with several asymptomatic, red, and scaly lesions on right thigh from 2 weeks. On examination, there were multiple discrete erythematous papules and plaques of varying size that were distributed unilaterally (right thigh-medial, anterior, and lateral aspect [Figure 1]. Dermoscopy of larger lesion revealed irregular distributed scale and brown structureless area in centre [Figure 2]. Potassium hydroxide mount did not show any fungal hyphae. There was no prior history of upper respiratory tract infection or any drug intake. Patient denied any history of sexual contact . Biopsy from representative lesions showed ulceration, crusting and perivascular lymphocyte infiltrate with extravasation of RBC in dermis [Figure 3]. Another 35-year-old female having asymptomatic red lesion over left neck from 1 week. Preceding history of URI was present. There was presence of multiple erythematous round to oval and few bizarre shaped papules and plaques. Few lesions showed peripheral semi-adherent white scaling [Figure 4]. Dermoscopy showed peripheral collarette scale and structureless area [Figure 5]. On histopathology epidermis showed hyperkeratosis, spongiosis, exocytosis, extravasated red blood cells and dermis showed perivascular

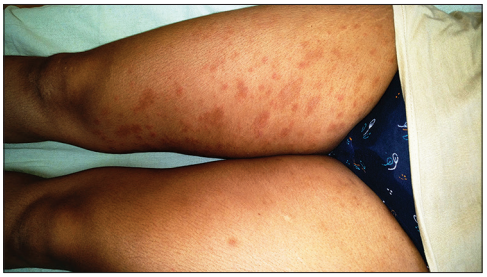

Figure 1: Multiple discrete annular erythematous papules and plaques that were distributed unilaterally over right thigh-medial, anterior and lateral aspect with Peripheral collarette scaling (Case 1)

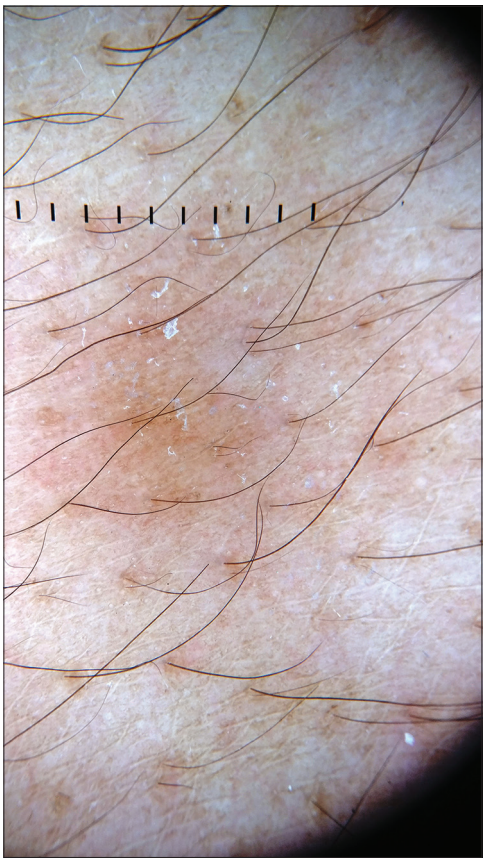

Figure 2: Dermoscopy of larger lesion revealed irregular distributed scale and brown structureless area in centre

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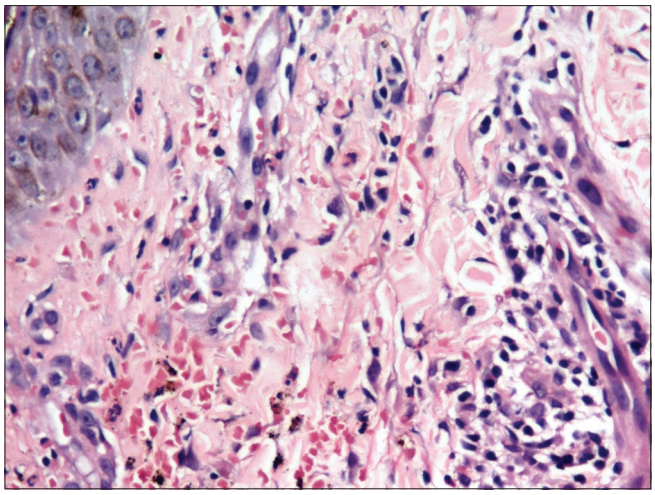

Figure 3: Microphotograph showing ulceration, crusting and perivascular lymphocyte infiltrate with extravasation of RBC in dermis (H&E, ×40)

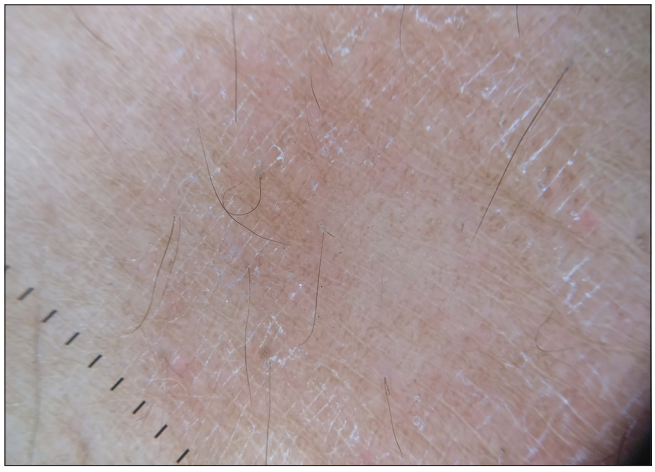

Figure 5: Dermoscopy of lesion showed peripheral collarette scale and brown structureless area

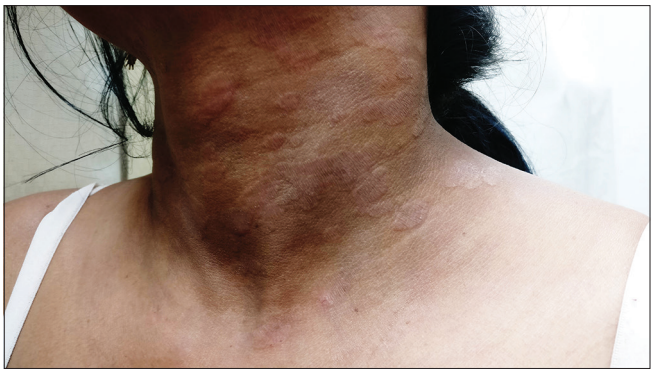

Figure 4: Multiple erythematous round to oval and few bizarre shaped papules and plaques. Few lesions showing peripheral semi-adherent white scaling (Case 2)

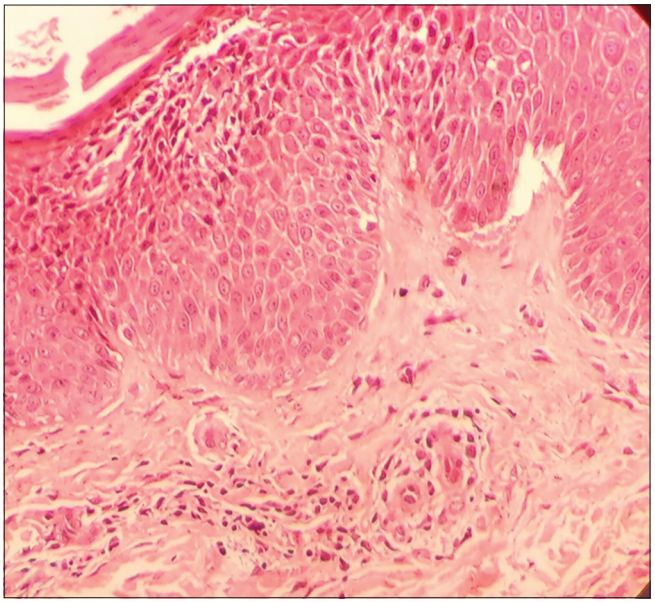

Figure 6: Microphotograph showing hyperkeratosis, spongiosis, exocytosis, extravasated RBCs, and dermis showed perivascular mononuclear infiltrate. (H&E, ×40)

mononuclear infiltrate [Figure 6]. The histopathologic and dermoscopic findings in both the cases helped us in making the diagnosis of pityriasis rosea unilateralis. The patients were counseled about the nature and course of the disease and were started on antihistamines and emollients.

Diagnosis of classical PR is straight forward but 20% of the patients who are having atypical presentation, can be misdiagnosed. Atypical types can be differentiated by size (Papular PR, PR gigantea of Darier), distribution (inverse PR, cephalic PR, unilateral PR, and pityriasiscircinata et marginata of Vidal), severities, cause of the lesions (like recurrent PR, relapse, annual relapse) and morphology.[2] Vesicular, pustular, hemorrhagic, purpuric, erythema multiform-like lesions have been reported.[2] Unilateral presentation of PR is rarely reported.Unilateral PR is difficult to diagnosis as morphology may not be classical, lesions may not appear scaly on naked eye examination as in our case. Dermoscopy gives a advantage by giving magnified view and scope to details which are not seen by naked eye. The unilateral/segmental presentation can be explained by increased responsiveness of a polygenic predisposed side of body to develop an inflammatory eruption directed against various infectious agents.[3] It can also be hypothesized due to mosaicism. More number of case reports are required to illustrate the exact pathogenesis of unilateral distribution of PR.[4]

Treatment includes counseling of patients regarding course of disease, emollients, antihistamines and topical corticosteroids. Systemic corticosteroids can be given if eruption is severe. In some cases, acyclovir can be used. Phototherapy (NB-UVB) can also be considered for severe cases. Pityriasis rosea during pregnancy has been linked to spontaneous abortions.[5]

Atypical cases of PR are uncommon hence misdiagnosed. Careful history, clinical examination

in conjunction with dermoscopy, histopathology, and follow-up are important to avoid misdiagnosis of PR. For atypical eruptions without a definite diagnosis, it is safer to consider lesional skin biopsy. Clinician should have high index of suspision for unilateral PR, so patient can be counseled about self limiting course of the disease and to decrease unnecessary over the counter treatments.

Declaration of patient consent

The authors certify that they have obtained all appropriate patient consent forms. In the form the patient(s) has/have given his/her/their consent for his/her/their images and other clinical information to be reported in the journal. The patients understand that their names and initials will not be published and due efforts will be made to conceal their identity, but anonymity cannot be guaranteed.

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Conflicts of interest

There are no conflicts of interest.

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