# Answers to dermatology quiz

1.1 Chromoblastomycosis

Photograph shows a Psoriasiform (psoriasis like) plaque. Psoriasis vulgaris usually presents with symmetrical bilateral multiple lesions (at least few lesions). Predilection sites for psoriasis are scalp, posterior auricular fold, external auditory meatus, extensors (knees/elbows/sacrum), nails and flexures. Psoriasis doesn't cause any skin atrophy and heals without scarring. Considering the duration, solitary nature and central clearance, this is very unlikely to be psoriasis vulgaris. In this scenario, other conditions such as malignancy (Bowes's disease/ squamous cell carcinoma in situ) or chronic infection (lupus vulgaris / tuberculosis cutis luposa) have to be considered as they present with solitary psoriasiform plaques.

1.2 Traumatic inoculation

Chromoblastomycosis is caused by traumatic inoculation of fungi through the skin by contact with wood splinters or thorns. The lesion develops as a warty nodule at first and grows slowly over the years at the site of implantation. The central parts of the lesion heal resulting in ivory-colored scars. The black dots observed in the lesion correspond to the transepidermal elimination of fungal elements, inflammatory cells along with minute haemorrhages.

2.1 Leonine facies

Leonine facies is a morphological manifestation due to diffuse dermal infiltration of face. Papules merge together into plaques resulting in deep creases. It has been classically described in lepromatous leprosy. Other differential diagnoses are chronic actinic dermatitis (actinic reticuloid), cutaneous T cell lymphoma (mycosis fungoides), lichen myxedematosus, progressive nodular histiocytosis, leishmaniasis, Morbihan's disease, and lipoid proteinosis. However, significant pruritus is only seen in chronic actinic dermatitis (actinic reticuloid)

2.2 Chronic actinic dermatitis/Actinic reticuloid.

3.1 Dermatomyositis

Photograph A shows an indurated plaque involving bi-lateral upper cheek and nasal bridge suggestive of a photosensitive eruption which mimics malar rash of lupus erythematosus. However, classic malar rash includes confluent erythema and mild oedema which spares the nasolabial folds. Classic cutaneous manifestations of dermatomyositis are heliotrope eyelids, gottron papules, nail fold telangiectasis, photosensitivity, calcinosis cutis and flagellate erythema.

He was started on methylprednisolone 16 mg daily. There was a remarkable improvement within a week.

3.2 Anti Jo-1(histidyl-RNA synthetase) antibody test

4.1 Photograph shows the peculiar clinical sign of localized hemorrhagic crusting of lower lip.

Vermilion border, upper lip, oral mucosae were spared. Steven Johnson Syndrome, Toxic Epidermal Necrolysis, Rowell's syndrome, mycoplasma-induced mucositis and pemphigus vulgaris like autoimmune bullous conditions are unlikely as aforesaid conditions usually involve mucosae. Although the site is compatible with actinic chelitis, it is a lip inflammation caused by long-term sun exposure. Bullous fixed drug eruption can mimic this morphology but there was no history of taking any medication. This lesion was fabricated by repeated rubbing with a piece of cloth every time he goes to the bathroom. Boy was house bound due to vast array of psychosocial problems.

4.2 Dermatitis artefacta.

5.1 Fish tank granuloma/Cutaneous Mycobacterium marinum infection.

Photograph shows acquired verrucous plaque (viral wart like) over the left middle finger. Differential diagnoses for acquired verrucous plaques are verruca vulgaris (viral wart), squamous cell papilloma, squamous cell carcinoma, lichen planus hypertrophicus, fish tank granuloma, swimming pool granuloma and Tuberculosis varruca cutis. History of cut injury and being an aquarist were more in favour of Fish tank granuloma. Skin biopsy is mandatory to confirm the diagnosis and to exclude malignant transformation. Long standing granulomatous inflammation can transform in to squamous cell carcinoma.

5.2 Clarithromycin, doxycycline and co-trimoxazole.