A Papulosquamous Eruption in a Pregnant Woman

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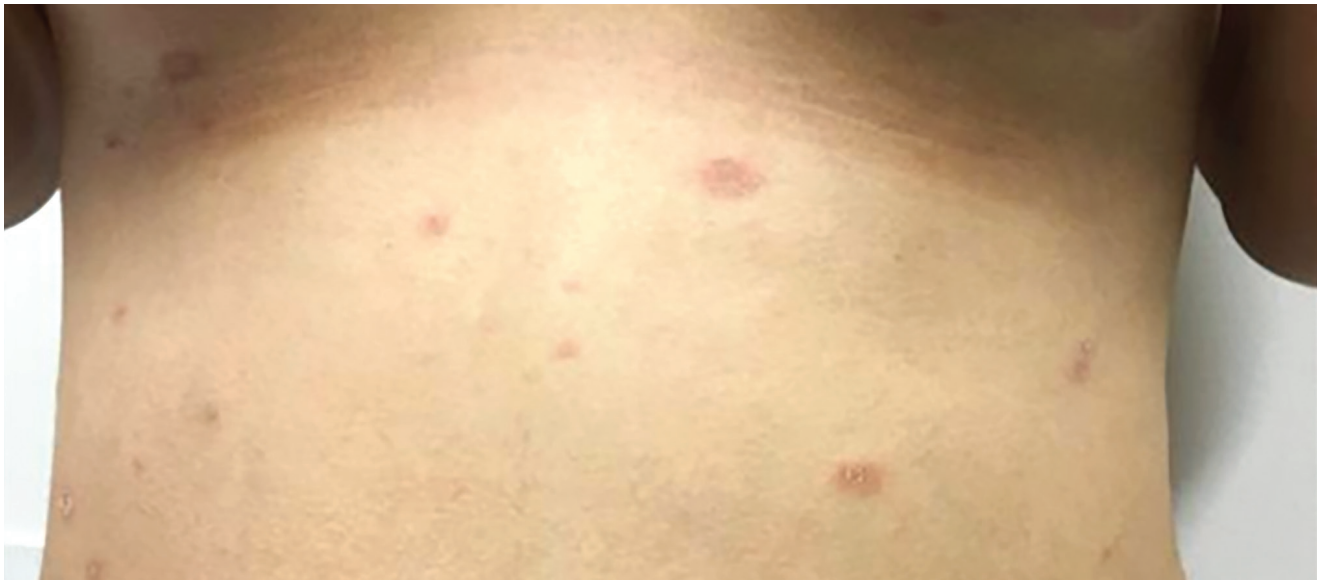

A 21-year-old primigravida woman at 21 weeks of gestation presented to the dermatology clinic for a rapidly developing, nonpruritic, scaly rash that had begun 1 week prior on her left flank and that had spread to her abdomen, breasts, and back. She did not report any systemic symptoms, she had no significant medical history, and her pregnancy had been uncomplicated.

Physical examination revealed a 3-cm ovoid plaque with overlying scale on the patient's left flank. There were an additional 25 to 30 similar, if smaller, lesions on the trunk (**Figure**). The patient was in no acute distress, and no lymphadenopathy was noted on palpation. Her vital signs were normal. Fetal heart tones were noted to be in the normal range.

Based on the patient's history and physical examination findings, which one of the following is the most likely diagnosis?

A. Atopic eruption of pregnancy
B. Polymorphic eruption of pregnancy
C. Pityriasis rosea
D. Pemphigoid gestationis
E. Tinea corporis

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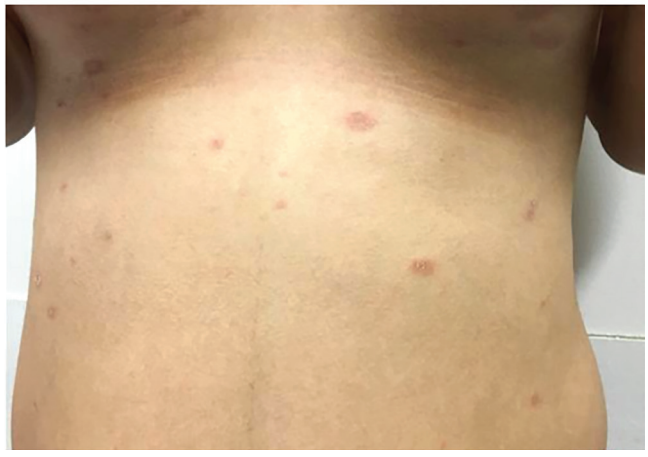
Answer: Pityriasis Rosea



Physical examination revealed a 3-cm ovoid plaque with overlying scale on the patient's left flank. There were an additional 25 to 30 similar, if smaller, lesions on the trunk, as demonstrated here.

The patient was diagnosed with pityriasis rosea (PR). The **Figure** shows the circular to ovoid, thin, rusty brown and salmon-colored plaques with central "trailing" scale that exemplify this condition. In addition, the large plaque on the patient's left flank was likely a classic "herald patch."

PR is an acute, self-limited papulosquamous eruption likely associated with systemic reactivation of human herpesvirus types 6 and 7.[1] The condition typically begins, as with this patient, with a single herald patch followed within hours to days by the eruption of many similar plaques along the Langer lines of the trunk—the so-called Christmas tree pattern.[2]

PR is a disease of young, healthy patients. In the nonpregnant population, it is managed symptomatically as a self-limited illness. Although data are limited in pregnancy, pregnancy-associated PR—particularly prior to 15 weeks of gestational age—has been associated with serious morbidity, including an increased risk of spontaneous abortion in severe cases of PR. For example, in one case series of 38 women who developed PR during pregnancy, 9 delivered prematurely and 5 miscarried; the rate of spontaneous abortion was 62% among women who developed PR within the first 15 weeks of gestation.[3]

DIFFERENTIAL DIAGNOSIS

Atopic eruption of pregnancy refers to the first occurrence or exacerbation of an underlying known atopic diathesis. This condition classically presents early in pregnancy with pruritic papules and often marked xerosis. Prognosis is excellent, and recurrence is almost guaranteed with subsequent pregnancies.

Polymorphic eruption of pregnancy (formerly called pruritic urticarial papules and plaques of pregnancy, or PUPPP) is a benign skin eruption associated with late gestation. This eruption tends to be quite pruritic, characteristically spares the umbilicus, and classically runs along the striae of the abdomen. It does not typically recur in subsequent pregnancies.

Pemphigoid gestationis is a rare autoimmune bullous disorder that classically occurs in late pregnancy. It is characterized by vesicle and bulla formation and can be diagnosed with skin biopsy and direct immunofluorescence staining. Recurrence is common in subsequent pregnancies, and the disease portends an increased risk of premature delivery and intrauterine growth restriction.

Tinea corporis is a dermatophyte infection of the body characterized by annular, erythematous plaques with "leading" or peripheral scale and central clearing. These are often pruritic, and such an exuberant, rapid onset of many lesions would be very atypical in an otherwise healthy patient. ■

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