Case Report

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Solitary pityriasis versicolor: an uncommon presentation as a large single patch: Report of three cases and review of unusual clinical forms

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Abstract

Pityriasis versicolor (PV) is a common disease, easy recognizable, that usually affects the trunk and upper limbs with multiple rounded scaly lesions which can vary in color from case to case. However, infrequent localizations have been reported, as well as diverse unusual clinical presentations, including atrophic, hyperkeratotic, annular, or inverse forms, among other. We describe 3 cases presenting with a single large lesion in the neck, which can hinder the diagnosis. No description of this form was found neither in large series of PV, nor in extensive reviews. This solitary variety would be just another atypical clinical presentation of PV. Clinicians should be aware of this variety in order to avoid unnecessary studies.

Keywords : Pityriasis versicolor, Tinea versicolor, Malassezia furfur.

Introduction

Pityriasis versicolor (PV) is a very common disease in daily practice and it is almost always easily diagnosed by any dermatologist, without the need for further laboratory analysis. However, in the last 10 years we have seen 3 cases of PV with an infrequent presentation, characterized by a single and large lesion located in the neck in all of them, which could hinder the diagnosis. No description of this form was found neither in large series of PV, nor in extensive reviews.

Case reports

Case 1: A 19-year-old woman in treatment with hydroxyurea for the last 18 months for essential thrombocythemia since birth, presented with an itchy lesion of two and a half months located on the left side of the neck. It consisted of of a slightly erythematous, scaly patch with irregular margins, about 7-9 cm in size (Figure 1). No similar lesions were found on the trunk or elsewhere. She had been initially treated with creams containing clotrimazole with betamethasone, or fusidic acid,

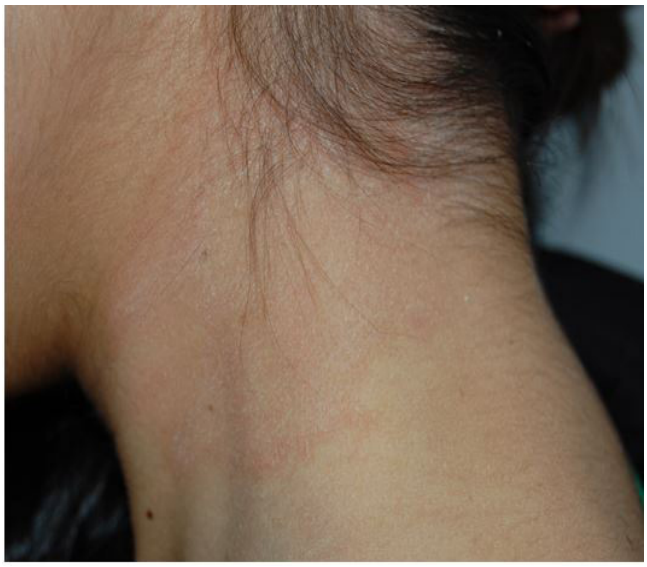

Figure 1: *Solitary erythematous scaly patch on the neck.*

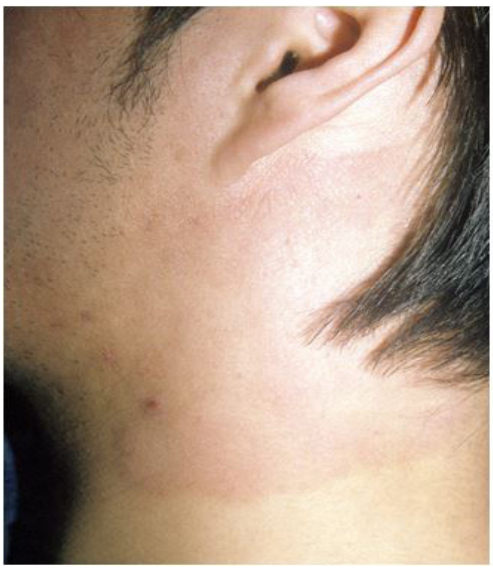

Figure 2: *Isolated, erythematous scaly patch on the neck.*

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with partial improvement, but returning to its initial state when the treatment was stopped. Direct mycological examination revealed yeasts in small amount and the culture yielded Malassezia sp. Oral itraconazole 100 mg/day for 15 days and ketoconazole shampoo were then prescribed. The patient did not return to control.

Case 2: A 24-year-old male similarly presented with a large erythematous scaly patch, also located on the left side of his neck, which had appeared six months earlier during summer time (Figure 2). No other lesions were detected. Direct microscopic examination showed numerous spores and short pseudomycelial filaments, and the culture yielded Malassezia furfur. The lesion improved completely after treatment with oral itraconazole 200 mg daily for one week. A year before, the lesion reappeared with identical characteristics in the same place. No predisposing factors were obtained after thorough questioning, including the use of high-necked garments, neckerchiefs, scarves, or headphones. He was treated again in the same way, and permanent weekly ketoconazol shampooing was recomended.

Case 3: A young male with an hypopigmented scaly patch on the right side of the neck (Figure 3) was also included in this report, although he was seen only once and did not return to control. Despite the fact that the diagnosis was not confirmed with a mycological study in this case, we decided to include it, as a counterpart to the preceding cases with erythematous scaly lesions, this time presenting rather with a hypopigmented, polycyclic, desquamative patch, that fully met the characteristic clinical and diagnostic features of PV, although as a solitary lesion.

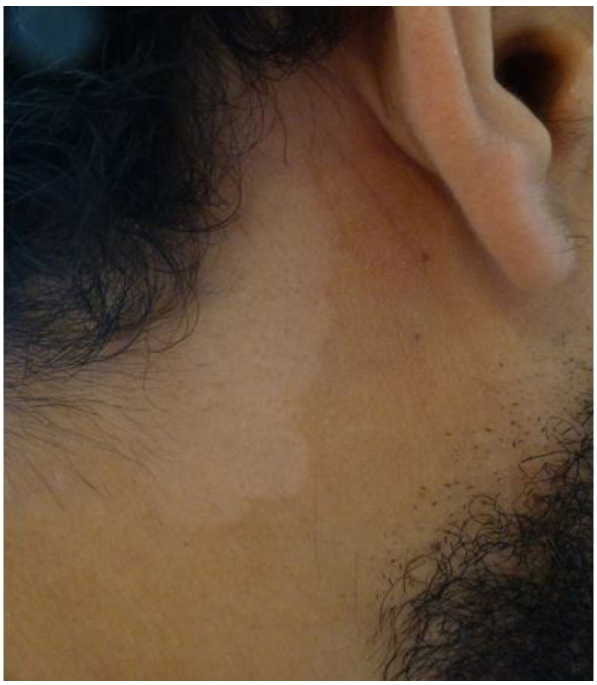

Figure 3: *Solitary polycyclic hypopigmented scaly patch on the neck.*

Discussion

PV occurs most often in young and healthy people, predominantly affecting the seborrheic areas of the trunk. It is favored by basal conditions of hyperhidrosis, seborrhea, tropical climates and habitual dressing with synthetic or occlusive undergarments. Clinically, in its usual form, it presents with multiple thin, irregular, isolated and/or confluent rounded scaly lesions with varying colors from patient to patient, ranging from hypopigmented to different hues of tan, light brown or pink. In typical cases the trunk is mainly affected, although involvement of unusual locations has been reported, including the scalp [1,2,3], eyelids [4,5], face [6] –although it is a common localization in children [7]-, axillae and groins [8,9], pubis [9], perineum [10], perianal, buttocks [11], popliteal [8,9] and antecubital fossae [2,9], web space [12], legs and arms [8], forearms [12], palms [13], nipple and areola [11,14,15], vulva [16], shaft of the penis [11,12,17,18,19], and glans [8,20,21]. It is not clear if there are specific predisposing or etiologic factors acting in the development of PV in those unusual locations [8]. Moreover, not always this nonclassical distribution of lesions occurs in conjunction with the typical eruption of PV, sometimes appearing as an isolated manifestation of it [8].

Some infrequent and quite different clinical presentations have also been described, including a follicular form [22,23], inverse [10] –also called tinea inversicolor [24]- and many others, such as erythematous or rubra [11], atrophic [11,25] –induced by topical corticosteroid application [26], as an idiosyncratic response to Malassezia [27] or a delayed type of hypersensitivity reaction to its epicutaneous antigens [28]-, erythrasmoid [29,30], rotundiform [31], hyperkeratotic [32,33], confetti-like [34] and annular variants [35]; in one report, both hyperpigmented and hypopigmented lesions were detected, with different response to therapy [36].

In large series of patients we have not found mentions of this variety, presenting as a large single patch, not either in extensive reviews of PV [21]. However, as single reports, we have encountered eight well documented examples in the English and Spanish literature, with isolated solitary lesions exclusively affecting the areolar and periareolar area [14], medial thighs [35], popliteal fossae [37], interdigital space, penile shaft [12], antecubital fossae [12], submammary region [38], and neck [39].

Although it is not uncommon in daily practice to observe large lesions of PV formed by the confluence of individual polycyclic patches, they usually retain small areas of intermingled and unaffected skin [38], or satellital rounded lesions in close proximity, a fact that did not occur in our patients, devoid of other lesions.

A rather different condition is perhaps that of rotundiform PV, in which a small, perfectly rounded, hypopigmented, scaly lesion appears as an early first episode of PV, analogous to the herald patch of pityriasis rosea [31]. We ignore the origin of this unique, unilateral and solitary presentation, similarly af-

fecting the neck in the three cases, and neither what caused the reappearance of the same lesion in the same place a year after in our second case (although recurrent episodes of PV are common). We can only mention that it would be important to keep in mind the possibility of solitary PV in the presence of a tenuous, erythematous or hypopigmented, desquamative patch, albeit solitary.

Conclusion

This solitary variety would be just another atypical clinical presentation of PV. Its recognition would be helpful in order to avoid unnecessary biopsies.

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