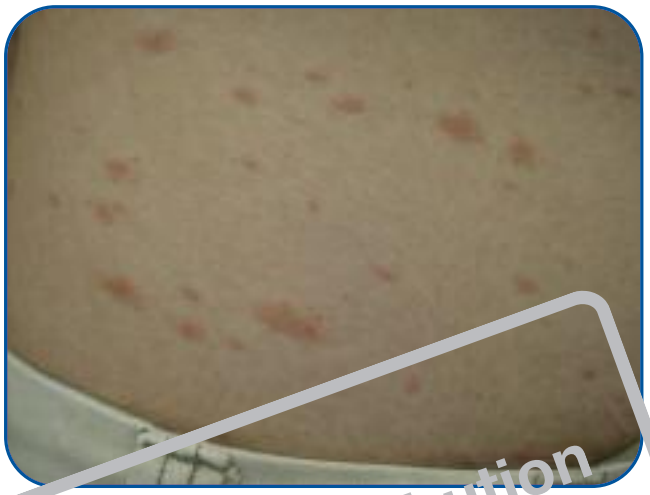
# Rashy Randy

**Benjamin Barankin, MD, FRCPC**

## Meet Randy

- Randy is a 34-year-old male with a rash that appears to have been spreading over the past few weeks. It is associated with some mild pruritus
- He originally noted a round, scaly, red spot on his abdomen, and a few days later, many more smaller rashy spots showed up on his abdomen and back, with only a few on his arms and legs, and none on the face, palms or soles



## What is your diagnosis?

a) Syphilis
b) Pityriasis rosea
c) Nummular dermatitis
d) Lichen planus
e) Tinea corporis



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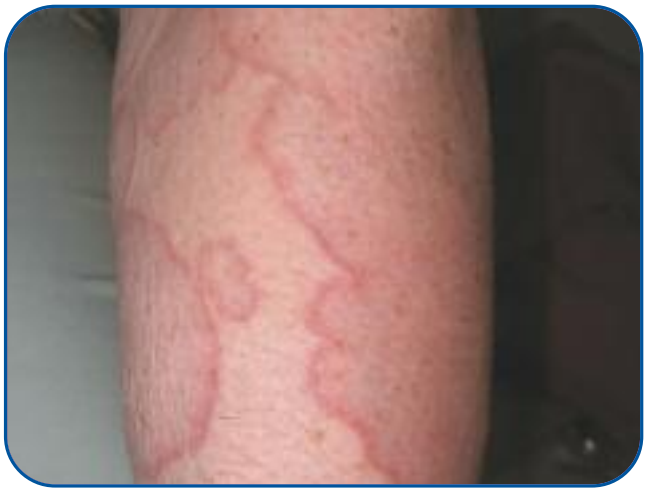
**See page 2 for the answer to last month's case**

# Here is the answer to last month's case

## Meet Shawna

- Shawna is a 42-year-old cashier with a four-year history of large, annular, erythematous plaques with slightly raised borders on her arms, chest and thighs. There is occasional pruritus
- She has a history of hypothyroidism and mild hypertension. She is on no medications
- She's tried various topical cortisone and antifungal creams, but nothing seems to work



## What is your diagnosis?

a) Tinea corporis
b) Granuloma annulare
c) Discoid lupus erythematosus
d) Nummular dermatitis
e) Psoriasis

## Answer: B

Granuloma annulare (GA) is a relatively common benign idiopathic inflammatory dermatosis. It is characterized by dermal papules and annular plaques. Several variants have been described, including localized GA (most common in children and young adults), generalized GA (generally found in middle-aged females), subcutaneous GA (mainly in children; M > F), perforating GA (most often in children; dorsal hands), and arcuate dermal erythema. This condition occurs in all races and ages. Granuloma annulare is likely an immune-mediated condition, with a hereditary basis in some cases.

Laboratory studies are seldom needed with a classic history and where typical annular red-brown non-scaly plaques on the extremities are present. Screening overweight patients with generalized GA for diabetes or thyroid disease is a reasonable consideration. Imaging studies are of no benefit, but they may help evaluate atypical subcutaneous lesions. A punch biopsy is recommended for a subcutaneous lesion and for an atypical presentation with respect to history (*i.e.*, rapid enlargement, pain) or location of lesion.

Treatment is based on the extent of the condition and how much the patient is bothered by the appearance of the plaques. For localized GA, intralesional triamcinolone acetonide (2.5 to 10 mg/ml) repeated every six to eight weeks is considered the most successful therapy. Potent topical steroids, with or without occlusion, are the next best option and are preferable in children. In Caucasian skin, cryotherapy can be a useful adjunct.

Generalized forms of GA are more difficult to treat and are less likely to resolve spontaneously. Patients are more likely to complain of pruritus. More aggressive therapy may be warranted due to presumed chronicity and prominent cosmetic disfigurement. Unfortunately the efficacy of systemic medications has been inconsistent and disappointing. The most widely used therapy for generalized GA is phototherapy (*i.e.* PUVA). Less commonly, systemic steroids, dapsone, retinoids, cyclosporine and hydroxychloroquine have provided anecdotal benefits.

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