Asymptomatic hypopigmented rash

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A man has recurrent, hypopigmented scaly lesions on his trunk. What are these lesions and how should they be treated?

A 34-year-old man had a history of recurrent, asymptomatic, hypopigmented scaly lesions on his trunk. The hypopigmentation was more prominent in summer because the lesions failed to tan (Figure 1). Skin biopsy showed multiple spores and hyphae in the stratum corneum (Figure 2).

Differential diagnosis

Multiple hypopigmented lesions can be seen in a number of dermatoses.

- **Vitiligo** presents with hypopigmented lesions that have a predilection for the acral and periorificial areas and extensor joints as well as the trunk. The loss of pigment is more absolute than is seen here, and the patches are white and lack an associated scale. Skin biopsy in vitiligo shows an absence of melanocytes in the epidermis.
- **Pityriasis alba** presents with ill defined patches of hypopigmentation, which often are larger than those seen here and are particularly localised to the face and upper limbs in dark skinned children. Atopic dermatitis may be present. Skin biopsy shows lymphocytic inflammation involving the epidermis, with focal pigment loss.
- **Postinflammatory hypopigmentation** may follow a wide range of inflammatory processes such as psoriasis, dermatitis or a viral exanthem in dark skinned individuals. Skin biopsy shows similar features to those found in pityriasis alba.
- **Pityriasis versicolor** is the correct diagnosis and is due to an overgrowth of a saprophytic skin organism called *Pityrosporum ovale*.

The term 'pityriasis' refers to the scaling seen clinically. 'Versicolor' refers to the reversal of colour as dark skinned individuals develop pale scaly lesions while on white skin the organism produces pink to light brown scaly spots. Wood's UV light examination can highlight the extent of the skin involvement. Skin scraping will demonstrate the clusters of spores and short hyphae typical of this organism.

Successful topical treatments, which need to be used over three nights, include shampoos containing selenium sulfide (Selsun), zinc pyrithione (Fongitar) or 50% propylene glycol in water. More recently, ketoconazole shampoo or imidazole foaming lotions have become available. Topical imidazole or terbinafine (Lamisil) creams can be used for localised disease. Recalcitrant or widespread involvement usually responds to a course of ketoconazole (Nizoral), fluconazole (Diflucan) or itraconazole (Sporanox) – usually given as a single dose or over a period of five days. Treatment may need to be repeated for relapses. Loss of pigment requires UV exposure for recovery.

Keypoint

A skin scraping should be taken from widespread hypopigmented lesions that are scaling because pityriasis versicolor can be readily diagnosed and treated. MT

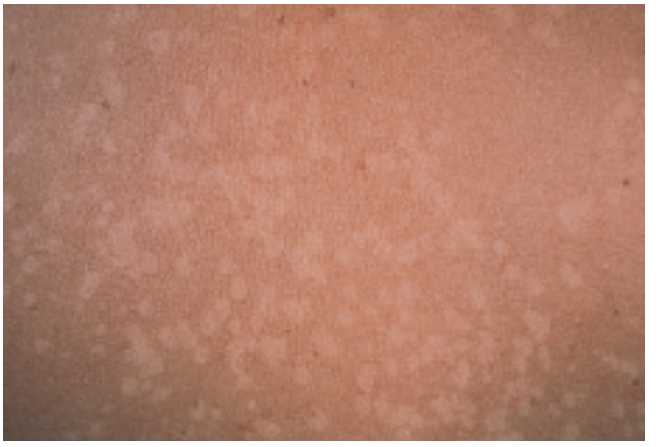

Figure 1. Numerous hypopigmented and slightly scaly lesions on the patient's back.

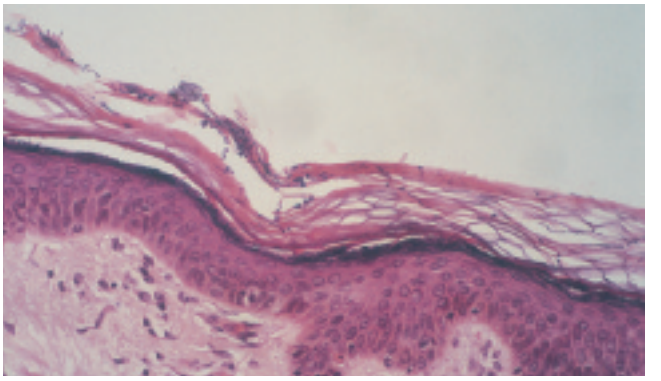

Figure 2. Skin biopsy demonstrating groups of spores and short hyphae in the stratum corneum.

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