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Narrative Review

Pityriasis Rosea

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KEYWORDS

Pityriasis Rosea,
Erythematous-desquamative rash,
Herald patch,
Epidermolytic collarette

ABSTRACT

The author provides an updated overview of Pityriasis Rosea, addressing its epidemiological, etiological, clinical - particularly emphasizing the increasingly frequent atypical variants - diagnostic, dermoscopic, and therapeutic aspects

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Introduction

Pityriasis Rosea of Gibert or Gilbert? Definying it Pityriasis Rosea of Gilbert it is still tempting…but with a mistake (1, 2). Has been described in a complete way by Camille Melchior Gibert, dermatologist (Paris 1797 – 1866) in his book: "*Maladies de la Peau*" in 1860 (3). The erythematous-desquamative lesions are distinctive in terms of their shape and typical progression, allowing a fast glance diagnosis or even on the phone.

Aetiology

Although it supports the infectious aetiology, the contagiousness has never been proven, even though small epidemics or the involvement of several members of the same family have been described in the literature (4). In support of the infectious aetiology, the onset was preceded by prodromal symptoms such as malaise, nausea, fever, headache, joint and gastrointestinal pain. The reactivation of latent human herpes infections (HHV6/7) (5) is assumed to be the most likely aetiology.

Epidemiology

The approximate incidence of Pityriasis Rosea (PR) ranges between 0.5 and 2%. Adolescents and adults between the ages of 15 and 30 are most frequently affected, but young children can be affected too. The littlest patient, of only three months of age, has been described in literature (6).

Mortality/morbility

PR is a benign self-limited disease associated with mild morbility with rash and occasional pruritus (7). It has can been associated with neonatal hypotonia, hyporeactivity, and premature delivery. An increased risk of miscarriage may occur, especially mothers who developed pityriasis rosea whitin the first 15 weeks of their pregnancy (8, 9).

Physiopathology

The physiopathology of PR is not entirely understood. However, a lack of natural killer (NK) cell and B cell activity PR lesions have been noticed, suggesting a predominantly T-cell mediated immunity. Increased CD4+ T - cells and Langerhans cells are present in the dermis, possibility reflecting viral antigen processing and presentation. In the blood, an increase in interferon alpha and gamma is observed (9, 20).

Histopathology

Hyperkeratosis, focal spongiosis, reduction/absence of the granular layer, perivascular and interstitial lymphocytic dermal infiltrate with epidermotropism are the most significant findings that can be observed (9).

Clinical

In its typical or complete forms, it appears in two phases:

Phase 1. Appearance of "*mother patch*" or "*herald patch*" or "*initial medallions*" located on the trunk (50% of cases), buttocks, proximal limbs or neck. It is generally single, round or oval in shape, with a larger diameter following the cutaneous tension lines of Langer (Fig. 1), erythematous-squamous with a cigarette-paper appearance, 2-10 cm in diameter, and yellowish-pink in colour. In this phase the dermatoscope is very important (10, 11).

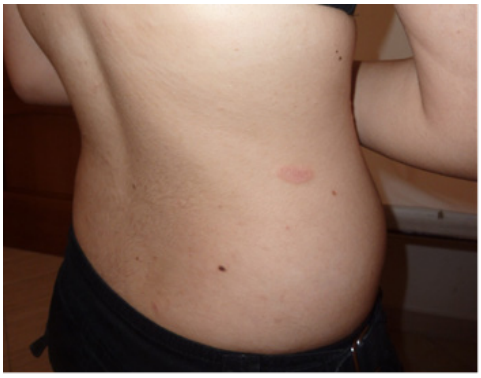

Fig. 1 *Typical herlad patch.*

Phase 2. After 1 to 2 weeks, a skin eruption appears with patches smaller than the initial *herald patch*, which persists (Fig. 2). These are generally non-confluent and rapidly spread across the trunk and the proximal limbs in a centripetal distribution. They are also arranged along Langer's lines, forming a whorled pattern on the chest, circular under the armpits, horizontal on the abdomen, and a Christmas tree-like pattern on the back (12).

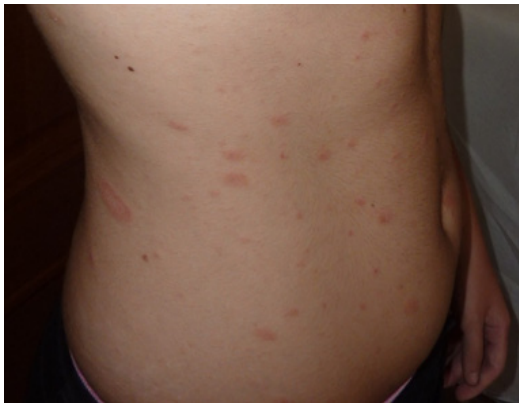

Fig. 2 *The eruption of numerous small.*

Small patches

In children the itching sensation is weak or absent in comparison with the adult patients (7). The rashes usually last for 5 weeks and resolve by 8 weeks in more than 80% of patients. The relapsing occurs in 1,8-3,5% of the cases (5). Dermatoscopy with epiluminescence highlights an epidermolytic collarette at the level of the small patches (10), which typically show a yellowish background color and a disorganized (patchy) distribution of red dots (capillary vessels) (11).

Over time, the new lesions become progressively smaller, less numerous, and less persistent. The *herald patch* regresses first (13). Generally, the oral mucosa is not affected, although the literature reports pinpoint hemorrhages, erosions and ulcerations, erythematous macules, and geographic tongue in this area (14). The skin lesions most often resolve with hypochromic outcomes, and rarely with hyperchromic ones.

Differential diagnosis

The main dermatological pathologies that enter into differential diagnosis with RP are erythema multiforme, guttate psoriasis, lichen planus, parapsoriasis, pediatric syphilis, pityriasis alba, tinea corporis, tinea versicolor, nummular eczema.

PR-like rashes have been reported after vaccinations against influenza A (H1N1), diphtheria, smallpox, pneumococcus, covid-19 and after taking isotretinin, nimesulide, rebinafine, dupilumab, rituximab, imatinib, adalimumab (20).

PR-like eruptions differ from classic pityriasis rosea by the absence of the herald patch and by a more inflammatory appearance of the lesions, which often have a reddish-violet color and are intensely pruritic.

The various atypical (15-20)

Not all patients with PR present with the typical form. Atypical variants are observed in approximately 20% of cases. Atypia may refer to differences in lesion morphology, size, number, distribution, symptoms, or clinical course.

Morphology: papular, vesicular, purpuric-haemorrhagic, psoriasic, urticaria-like, lichenoid, multiforme-like, follicular.

Morphology and Topography: circinata and marginata of Vidal.

Herald patch: absent, 2 or more, delayed, persistent.

Number: few or many giant lesions

Topography: face, neck, armpit, limb(s), groin, lateral back, unilateral (dermatomal)

Course: abortive, rapid onset (less than two weeks), relapsing, faster course.

Persistent: longer than 3 months with asthenia, insomnia and other systemic symptoms.

Treatment/Management

PR is a self-limiting condition, so despite its striking appearance, no treatment is strictly necessary, and none has proven to be significantly effective. In addition to general measures such as the use of emollients and gentle cleansing with bath oils, some patients benefit from cautious sun exposure, the use of macrolides, and sedating antihistamines in cases of itching (20).

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