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Regarding Rashes: An Exploration of Diagnostic Dilemmas & Guiding Principles

Dr. Weiss:
You're listening to *DermConsult* on ReachMD. I'm your host Dr. Jon Weiss, and I was recently asked if I had ever encountered a patient case where I wasn't sure of the diagnosis and what my response was. Well, I have to tell you, this question brought a smile to my face!

Dealing with unknown diagnoses is part of being a dermatologist and the sign that one is a good or experienced dermatologist is that they get comfortable with this concept. Not knowing is not a bad thing. The important issue is that a dermatology provider knows how to work-up the patient in whom he or she does not immediately know the diagnosis. In our practice, where we have 14 providers and see a high volume of patients, encountering cases with unknown diagnoses may be a daily or weekly occurrence. At any given time, we will have multiple patients that present diagnostic dilemmas. Following, I will outline our approach to these patients.

While exceptions likely exist, in my experience there are two major diagnostic categories that create uncertainty: rashes and tumors (or masses). I will approach the tumor issue first because it is a simpler answer: For a tumor mass or fluid filled growth for which I am uncertain of a diagnosis, I first determine that the lesion is not of vascular origin or is not along a suture line of the skull through which meninges can be herniating. Once I am certain of this, a biopsy can be performed, and the diagnosis is generally obtained. If there is uncertainty regarding the vascular nature of the mass or if it may be of questionable origin, imaging can be performed, or the patient can simply be referred to an appropriate surgeon or surgical sub-specialist.

With regard to rashes, I have found that uncertainty can fall into one or more of several categories:

1. Difficulty distinguishing between two common rashes.
2. Truly unknown or unrecognizable rashes.
3. A seemingly obvious rash diagnostically that does not respond to therapy.

In the first instance, all dermatologists know that there are overlapping morphologic appearances between some rashes. We are all too familiar with the patient that has a well-demarcated eczematous appearing eruption over extensor surfaces. We ask ourselves: Is it eczema or psoriasis? A biopsy is performed and reads "psoriasiform and spongiotic dermatitis." So depending on the intricacies of the biopsy, such as presence or absence of eosinophils, it may not help to further elucidate the diagnosis. However, the biopsy report can point us in a therapeutic direction. A biopsy such as this can also be helpful if cutaneous T-cell lymphoma, or CTCL, is in the clinical differential or even if it is not. Therapeutically, there would be specific medications to avoid if CTCL was the diagnosis.

For patients who present with truly unknown or unrecognizable rashes, I have found that one of two scenarios may be occurring: The rash is an uncommon presentation of a common diagnostic entity, or the rash is a classic presentation of an uncommon/previously unseen entity. In either case, biopsy can be extremely helpful. In rashes with an uncommon presentation, there may be more than one morphology present, and each morphology should be biopsied.

Rashes that can be most concerning are those for which the diagnosis is seemingly obvious, but the response to therapy is poor or unexpected. Over my career, this has occurred under several circumstances, most commonly with psoriasis. I have seen proven psoriasis patients who had had biopsies showing that diagnosis convert to CTCL. So never hesitate to re-biopsy a known rash that changes in character or therapeutic response. More recently with the advent of biologic therapies, we have seen patients with clear-cut atopic dermatitis treated with a biologic transform into a psoriasiform presentation, and some psoriasis patients, on the other hand, who are under treatment with biologics for psoriasis take on more of an atopic phenotype. Having discussed this with several experts in both

areas, atopic dermatitis and psoriasis, this appears to be an observed phenomenon that has yet be fully explored or discussed. Biopsies have not proven particularly useful in this situation, though again if CTCL is a concern, a biopsy should be performed.

To conclude, regardless of the diagnostic dilemmas that rashes present, there are several guiding principles that have worked for me:

1. “Share the wealth”: get multiple providers to look at the rash, interview the patient, and give independent opinions on diagnosis and therapeutics and also the work-up.
2. If you are in a solo practice situation, NETWORK. Share with colleagues and get their opinion. Ask the patient for permission to share photos of their eruption and their reports with other dermatologists.
3. Perform biopsies for routine pathology, and if appropriate, immunofluorescence and cultures.
4. Order other lab tests as appropriate.
5. Go back to basics. If it scales, perform a KOH preparation. If it blisters, maybe a zinc preparation.
6. Most importantly, gain the patient’s confidence by listening and assuring them you care. Set frequent follow-up visits and/or go the extra mile and call them between visits.
7. Do not be hesitant to refer to a major referral center, even if it is in an adjacent state for particularly difficult cases.

For ReachMD, I’m Dr. Jon Weiss. To access this and other episodes in our series, visit ReachMD.com/DermConsult, where you can Be Part of the Knowledge. Thanks for listening!