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Pityriasis Rosea of Gibert: A Comprehensive Review of a Common, Self-Limiting Dermatologic Entity

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ABSTRACT

Pityriasis rosea of Gibert is a common, self-limiting dermatologic entity that continues to raise questions regarding its etiology, diagnosis, and clinical management. This comprehensive review focuses on analyzing the distinctive clinical presentation of pityriasis rosea, characterized by the appearance of a herald patch followed by multiple secondary collarete or Christmas tree lesions. Although the exact cause of this disease remains unknown, a possible relationship with an immune reaction triggered by a previous viral infection or environmental factors yet to be identified is postulated.

Through a thorough literature search, current findings on the epidemiology, pathogenesis and clinical diagnosis of pityriasis rosea are evaluated. The importance of the clinician's clinical judgment and accurate identification of the distinctive features of the skin lesions to reach an accurate diagnosis is emphasized.

Although pityriasis rosea is usually asymptomatic or causes mild pruritus in most cases, symptomatic therapeutic options, such as the use of oral antihistamines and low potency topical corticosteroids, are described to alleviate patient discomfort when necessary. Patient education and psychological support are essential to decrease the anxiety associated with skin lesions and to provide reassurance during the self-limiting course of this condition.

In the context of the clinical and epidemiologic relevance of pityriasis rosea, the need for continued research to improve understanding of its etiology and management arises. Although pityriasis rosea does not represent a serious health threat, its high frequency in the population and its distinctive clinical appearance underscore the importance of empathetic and compassionate medical care to ensure the patient's well-being during the process of spontaneous resolution.

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INTRODUCTION

Pityriasis rosea, also known as pityriasis rosea of Gibert, is a benign, self-limiting dermatologic disease of unknown origin, belonging to the group of exanthemata or cutaneous eruptions. It is characterized by the appearance of pink, oval or scaly skin lesions, which tend to cluster symmetrically on specific areas of the body.1

This dermatological disorder usually manifests initially with a skin lesion called a "herald patch", which presents as an oval or round pinkish plaque with a darker border. Subsequently, over a period of days to weeks, multiple smaller secondary skin eruptions, known as "secondary lesions," develop and are typically distributed in a "tree-branch" or so-called "pigtail" fashion.1,2

Pityriasis rosea, a benign and self-limiting dermatologic disorder, is of clinical relevance due to its frequent presentation in the population, particularly in young and healthy individuals, being one of the most common cutaneous eruptions in this category. Despite its benign nature, its characteristic appearance can generate concern and anxiety in patients, leading to medical consultations and a need for diagnostic clarification.2

EPIDEMIOLOGY

The epidemiology of pityriasis rosea is a matter of clinical interest due to its frequency in the general population and its pattern of presentation, which mainly affects young individuals and young adults. It is considered a common, self-

limiting dermatologic disease, showing a universal distribution in all geographic regions.3

The incidence of pityriasis rosea shows a clear peak in young, healthy people, with a typical age range of 10 to 35 years, although it can occur in people of all ages, including children and the elderly. Although a pattern of gender predilection has not been established, some studies suggest a slight preponderance in women. This apparent preeminence in the younger population has led to the hypothesis of a possible association with infectious or viral factors, although to date, no specific infectious agent has been identified as a trigger for the disease.3

The exact etiology of pityriasis rosea remains unknown, limiting a complete understanding of its epidemiology. No clear genetic predisposition has been demonstrated, but occasional familial cases have been reported, suggesting a possible hereditary component in its development. The incidence of pityriasis rosea also appears to exhibit some seasonal variation, with an increased frequency of cases reported in autumn and winter.3

In terms of transmission, it has been shown that pityriasis rosea is not contagious from person to person, suggesting that it is not the result of an infectious agent transmitted directly between individuals. Instead, the most widely accepted theory is that the disease may be related to an immune reaction triggered by a previous viral infection or a response to an as yet unidentified environmental stimulus.3,4

The geographic presentation of pityriasis rosea is broad and shows no predilection for any specific region of the world. Cases have been documented in several countries and continents, suggesting that there are no significant geographic factors influencing its occurrence.4

CLINICAL PRESENTATION

The clinical presentation of pityriasis rosea is characterized by a peculiar and evolving cutaneous presentation that follows a typical and self-limited course, although it may cause concern to the patient due to its distinctive appearance. This dermatologic entity usually starts with a singular skin lesion called "herald patch", which presents as a round or oval pink to reddish plaque with a darker border that can reach a variable size, usually larger than 2 cm in diameter. This heraldic lesion, although sometimes asymptomatic, may be associated with mild pruritus in some patients.5

After the appearance of the herald patch, pityriasis rosea progresses to the secondary phase, in which multiple smaller secondary skin lesions, known as "secondary lesions" or "satellite outbreaks", develop. These secondary lesions tend to occur in similar areas of the skin, following a "collarete" or "Christmas tree" pattern, where newer lesions are distributed peripherally around the initial lesion, generating a characteristic chain or necklace-like appearance. These secondary lesions are typically oval or oval, smaller than the herald patch, and are pink to light brown in color. Occasionally, they may have a raised, scaly border.5

The preferential distribution of pityriasis rosea lesions occurs on areas of the trunk, such as the back, chest and abdomen, although the arms and legs may also be affected. In general, the rash does not usually extend to the face, palms of the hands or soles of the feet, which allows it to be distinguished from other exanthematous diseases.5

Throughout the course of the disease, which usually lasts 6 to 8 weeks, pityriasis rosea lesions may undergo changes in appearance, such as a central clearing that confers a "ring" appearance, sometimes referred to as "bull's-eye" or "reverse bull's-eye" erythema. During the acute phase, some lesions may show mild to moderate pruritus, which may cause discomfort to the patient.5

Although pityriasis rosea does not usually present with systemic symptoms, such as fever or general malaise, the appearance of distinctive skin lesions may lead patients to seek medical attention for proper diagnosis and treatment.6

DIAGNOSIS

The diagnosis of pityriasis rosea is essentially clinical and is based on careful evaluation of the typical features of the skin lesions and the patient's clinical history. Since pityriasis rosea shows a distinctive clinical presentation, with a characteristic sequence of lesion development, the physician, and especially the dermatologist, plays a key role in the accurate identification of this dermatologic entity.7

The diagnostic process begins with careful observation of the herald patch, which is an oval or round pink to reddish skin lesion with a darker border. This initial lesion is typically located on the trunk and is usually larger than 2 cm in diameter. The presence of this heraldic spot and its distinctive appearance may provide the clinician with a first clue to suspect pityriasis rosea.7

Once the herald patch is identified, the physician will focus on examining the secondary lesions or "satellite outgrowths" that develop later. These secondary lesions are typically smaller, oval or oval, pink to light brown in color, and tend to cluster around the herald patch, following a characteristic "pigtail" or "Christmas tree" pattern. The presence of this peripheral distribution of secondary lesions is highly suggestive of pityriasis rosea.7

In addition to the clinical appearance, the physician can also evaluate for the presence of associated pruritus, although this symptom can vary in intensity and is not always present. A thorough clinical history can be taken to rule out other dermatologic conditions with similar presentations and to verify the absence of relevant risk factors that may point to differential diagnoses.7

In atypical cases or when the clinical presentation is inconclusive, the physician may resort to complementary tests to confirm the diagnosis. However, there are no specific tests or highly sensitive or specific laboratory tests for pityriasis rosea. Occasionally, histopathologic examination of a skin sample may be performed to rule out other diseases and to observe microscopic features such as spongiosis,

superficial and dermal perivascular infiltrate, and epidermal spongiosis, which may support the diagnosis.7

It is important to note that the diagnosis of pityriasis rosea is primarily one of exclusion, meaning that other conditions with similar presentations must be ruled out before a definitive diagnosis can be made. In this context, the clinician's clinical experience and ability to recognize the distinctive features of pityriasis rosea are critical to reaching an accurate conclusion.7,8

The diagnosis of pityriasis rosea is based on careful clinical evaluation of the typical features of the skin lesions, the sequence of lesion development, the distribution on the body, and the patient's clinical history. Although there are no specific tests to confirm the diagnosis, the distinctive clinical appearance and the exclusion of other diseases with similar presentations support the accurate identification of pityriasis rosea. Consultation with an experienced dermatologist is recommended to ensure accurate diagnosis and appropriate treatment.8

TREATMENT

Treatment of pityriasis rosea focuses primarily on symptomatic management of associated discomfort and patient support, as this disease is self-limiting and tends to resolve on its own over a period of time that can range from weeks to months. There is no specific therapeutic approach to cure pityriasis rosea, as its exact cause remains unknown, and its natural course is benign and poses no significant health risk.9

In many cases, pityriasis rosea may be asymptomatic or cause only mild symptoms, so simple observation and reassurance of the patient is sufficient. However, when pruritus or itching is prominent and affects the patient's quality of life, therapeutic measures can be used to alleviate symptoms.9

The most commonly used pharmacologic treatment for pruritus associated with pityriasis rosea includes the administration of oral antihistamines, such as cetirizine or loratadine, which help reduce the inflammatory response and itching of the skin. In addition, low-potency topical corticosteroids, such as hydrocortisone, can be applied to lesions to reduce local inflammation and itching.10

To alleviate itching and dry skin, it is recommended to avoid prolonged hot showers or baths and to use mild, emollient soaps during daily hygiene. The application of moisturizing lotions or creams can help to keep the skin hydrated and relieve skin dryness.9,10

It is important to note that some topical treatments or medications may not be suitable for all patients, especially those with underlying skin conditions or known allergies. Therefore, it is essential that a healthcare professional, such as a dermatologist, assess each patient's condition individually and recommend the most appropriate treatment.10

In addition to pharmacologic treatment, counseling and psychological support should be provided to the patient to reduce anxiety and worry associated with the appearance of the skin lesions. Education about the self-limiting nature of pityriasis rosea and the expectation of spontaneous resolution over time are important aspects of reassuring the patient and avoiding unnecessary interventions.10

Treatment of pityriasis rosea focuses on symptomatic management of pruritus and associated skin discomfort. Although there is no specific cure for this disease, the use of oral antihistamines and low potency topical corticosteroids can provide relief to the patient when pruritus is prominent. General skin care measures, such as avoiding prolonged baths with hot water and the application of moisturizers, may also be beneficial in relieving skin dryness. Education and psychological support are essential to reassure the patient and provide comprehensive and compassionate medical care during the self-limiting course of this dermatologic entity.10

CONCLUSION

In conclusion, pityriasis rosea is a common and benign dermatologic entity characterized by the appearance of distinctive skin lesions and a self-limited course. Although its etiology remains unknown, it is believed that pityriasis rosea may be related to an immune reaction triggered by a previous viral infection or as yet unidentified environmental factors. The typical clinical presentation of this disease, which includes the presence of a herald patch followed by multiple secondary collarete or Christmas tree lesions, provides a key element for an accurate clinical diagnosis.

Although pityriasis rosea generally does not cause serious complications or require specific treatment for resolution, it may be associated with pruritus in some patients, affecting the quality of life and comfort of the individual. In these cases, symptomatic treatment, such as the use of oral antihistamines and low potency topical corticosteroids, can be employed to alleviate skin discomfort. However, it is essential to consider the individual characteristics of the patient and the possible contraindications of the medications before prescribing any treatment.

Patient education and counseling play an essential role in the management of pityriasis rosea, as knowledge of its self-limiting nature and benign course can reduce the anxiety and worry associated with skin lesions. Consultation with an experienced dermatologist is crucial to ensure accurate diagnosis and comprehensive care, giving the patient the confidence to face the process of spontaneous resolution.

Although pityriasis rosea does not represent a significant health risk, its clinical relevance lies in its high frequency in the population, especially in young individuals and young adults. In addition, the appearance of the skin lesions may generate concern in the patient, highlighting the importance of an empathetic and compassionate medical approach.

In the field of medical research, pityriasis rosea continues to be of interest due to uncertainty about its etiology and the search for more effective therapeutic approaches for the relief of the associated pruritus. Further studies are needed to fully

understand the underlying mechanisms of this disease and to improve its clinical management.

Pityriasis rosea is an intriguing dermatologic condition that, although it continues to pose challenges in terms of its etiology and treatment, is recognized for its distinctive clinical presentation and self-limiting course. Knowledge and understanding of this entity by healthcare professionals is essential to provide optimal medical care and reassurance to the patient during the process of spontaneous resolution.

REFERENCES

I. Chuh A, Lee A, Zawar V, Sciallis G, Kempf W. Pityriasis rosea - an update, Indian J Dermatol Venereol Leprol, 2005; 71: 311-315.

II. Ozge G, Siebel E, Aysen K. Childhood pityriasis rosea, Ped Dermatol, 2009; 26: 750-751.

III. Raspa ML. Pityriasis rosea. In: Larralde M, Abad ME, Luna P, Dermatología pediátrica, 2nd edition, Buenos Aires: Ediciones Journal; 2010: 414-416.

IV. Rebora A, Drago F, Broccolo F. Pityriasis rosea and herpesviruses: facts and controversies, Clin Dermatol, 2010; 28: 497-501.

V. López-Carrera I, Durán-McKinster C, Sáez-de-Ocariz MM, Orozco-Covarrubias L, Palacios-López C, Ruiz-Maldonado R. Pityriasis rosea: an exanthem that should be recognized by the first contact physician. Study of 30 cases, Acta Pediátr Mex, 2014; 35: 289-294.

VI. Gonzalez LM, Allen R, Janniger CK, Schwartz RA. Pityriasis rosea: An important papuloscamous disorder, Int J Dermatol, 2005; 44: 757-764.

VII. Jacyk WK. Pityriasis rosea in Nigerians, Int J Dermatol, 1980; 19: 397-399.

VIII. Drago F, Vecchio F, Rebora A. Use of high-dose acyclovir in pityriasis rosea, J Am Acad Dermatol, 2006; 54: 82-85.

IX. Rassai S, Feily A, Sina N, Abtahian S. Low dose of acyclovir may be an eff ective treatment against pityriasis rosea: a random investigator-blind clinical trial on 64 patients, J Eur Acad Dermatol Venereol, 2011; 25: 24-26.

X. Sharma PK, Yadav TP, Gautam PK, Taneja N, Satyanarayana L. Erythromycin in pityriasis rosea: a double-blind, placebo controlled clinical trial, J Am Acad Dermatol, 2000; 42: 241-244.