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PITYRIASIS ROSEA, AN EXANTHEMATOUS REACTION

Editorial

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Dermatological emergencies are rare events that can be caused by acute medical conditions, with or without systemic involvement, or by chronic diseases when exacerbation is observed.

Exanthematous diseases are one of the leading causes of dermatological emergencies and may include a broad spectrum of diagnoses. Depending on their causes, they are classified as infectious (viral, bacterial, parasitic, and fungal), immunological, inflammatory, neoplastic, or caused by adverse drug reactions. The diagnosis of an exanthem is based on the patient's medical history; however, in some cases it is necessary to perform complementary laboratory tests and pathology studies to confirm it.

Pityriasis rosea (PR) was first described in 1860 by Dr. Camille Melchior Gibert, a renowned French dermatologist who opposed the iconography of the time by stressing that "to get to know things in depth, you must first see them. Nothing can replace direct observation, which can only be done by a professional physician" (1).

PR is an exanthematous disease of sudden onset that in some cases appears after experiencing mild symptoms similar to those of an upper respiratory infection. It usually begins with a small, fawn-colored, oval-shaped plaque with fine scales along the borders of the ring, which Louis-Anne-Jean Brocq named primitive or herald patch in 1897 (1). Then, 2 weeks after the onset of symptoms, multiple annular or rounded, reddish, scaling plaques, smaller than the initial lesion, appear in a linear pattern or in the shape of a "Christmas tree." Lesions caused by PR may be vesicular in nature and have hypopigmented macules during the involution phase.

This disease is more common in people between the ages of 15 and 40 and usually has a spontaneous resolution (2-4). Its diagnosis is based on clinical findings and laboratory

tests, but syphilis serology (VDRL and FT-ABS) and mycology tests (2-4) should be requested for confirmation; a skin biopsy may also be necessary. The main differential diagnoses of this condition are syphilis, tinea, and other exanthematous diseases (5).

The main cause of PR is reactivation of human herpesviruses 6 and 7 (6), and its treatment is based on topical corticosteroids, UVB phototherapy, emollients, oral acyclovir (7-10) or erythromycin at a dose of 25-40 mg/kg/day or 250mg every 8 hours for 15 days in adults (9).

The current issue of Case Reports presents the case of a 28-year-old woman diagnosed with PR and treated with deflazacort 30mg for 21 days, who had a favorable evolution and complete improvement of symptoms after 2 months (11). With this article, the authors stress the relevance of performing an in-depth study of the medical history, the diagnostic difficulties of this condition, and the differential diagnoses to be considered. Likewise, this case report stands out as evidence of the importance of primary care physicians having adequate training in dermatology so that they can recognize and treat PR, since its diagnosis is eminently clinical, and it can have multiple atypical presentations. In this sense, it will surely be a reference text.

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