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Case Series

Cases on Simultaneous Multiple Dermatologic Diagnosis

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ABSTRACT

General Practice doctors in Primary Health Care see patients, of which about 10% are estimated to be related to skin issues in Finland. Some patients are referred to a dermatology specialist, often by only one referral diagnosis. At specialist appointment, also other undiagnosed skin manifestations may be found and all of them shall be paid attention to.

Keywords: Dermatology; Multiple diagnosis; Consultation

Introduction

Patients with dermatologic disorders are an important public health concern[1] and the patients may have more than one skin disease. It was estimated that more than 94 million Europeans complain of uncomfortable skin sensations like itch, burning or dryness. The most frequent conditions were fungal skin infections (8.9%), acne (5.4%) and atopic dermatitis or eczema (5.5%). Alopecia, acne, eczema and rosacea were more common in women, whereas men were more likely to suffer from psoriasis and sexually transmitted infections[1].

General Practioners (GPs) in the Primary Health Care especially in rural areas often seen naiive and new skin diseases and due to requirement of wide medical knowledge, the dermatology knowledge of GPs is limited and, thus, they may consult Dermatology specialists to ensure diagnosis and best treatment for the patient.

Also in a tertiary hospital, dermatologists are consulted to ensure improved diagnosis and management of cutaneous issues early with the aim to minimize unnecessary investigations, improve the quality of healthcare, reduce hospital burden and facilitate outpatient follow-up[2].

At a specialist appointment, more than one skin issue may be detected. Thus, the dermatology specialist need to examine carefully the patient's whole skin and keep in mind simultaneous different and variants of dermatologic disorders at the same time in the same patient. We describe 4 cases with different dermatologic diagnosis as examples of multiple simultaneous diverse skin manifestations of a patient needing to pay attention to.

Case Reports

Case 1

A female born in 1964 had coeliacia and dermatitis herpetiformis both been in a stabile stage by diet. She also had alopecia areata developing to total alopecia areata 4 years later and she weared a wig. She had also diagnosed a mild dermatitis atopica. Rhinitis symptoms were present during spring time for birch pollen and she experienced symptoms from apple, kiwi, tomato and raw potato. In 2013 at dermatology clinic, psoriasis vulgaris lesions on soles and dorsal aspects of hands were

detected. Topical treatments included emollients, strong (Class III) and superpotent (Class IV) corticosteroids and calcipotriol-betamethasone ointment and later calcipotriol-betamethasone foam.

Patient files from 1998 informed a Phenoxymethylpenicillin allergy due to throat infection with a guttate psoriasis developed that was treated topically. However, no antibiotic medication was used in reality.

In summer 2024, her psoriasis worsened with also guttate-type lesions. Methotrexate was considered but continued by topical treatments.

Case 2

A male born in 1959 was sent in 2014 to Dermatology clinic by a General Practioner (GP) referral due to treatment-resistant wide psoriasis vulgaris treated topically by emollients and strong (Class III) corticosteroids and calcipotriol-betamethasone ointment. The patient was also diagnosed with Birt-Hogg-Dube genodermatosis that has an increased risk for renal malignancy and pulmonary emphysema needing a follow-up.

At dermatologits' patient meeting, acitretretin 25 mg daily was started with a good response and laboratory follow-up, with previous topical treatments. UVB light therapy was unpractical due to patient's long distance to University Hospital for treatments.

In summer 2022, psoriasis started to worsen. In December 2022 acitretin was changed to metotrexate 10 mg/week with 5 mg folic acid with a good response as followed to Jan 2025. Tacrolimus 0.1% ointment was used for facial psoriasis and to other areas calcipotriol-betamethase foam with topical steroids and emollients were used.

Case 3

A male born in 1951 with Type 2 diabetes came in 2017 to Dermatology clinic by a GP referral due to itchy dermatitis in upper extremities, head and beard area. Histology revealed unspecific dermatitis and serum transglutaminase-Abs were negative. Patient had started glutein-free diet and felt his skin situation better.

Dermatologist diagnosed seborrheic dermatitis and clinically lichen planus in antebrachial areas. These were treated by topical miconazole-hydrocortisone or triamcinolone-econazole cream and cyclopirox olamine shampoo, and methylprednisolone cream for lichen planus. In addition, at his left lower back, there was a suspicious pigmented lesion that was excised with diagnosis of superficial Breslow 0.8 mm melanoma. New biopsies were taken from antebrachial blistering lesion: histology revealed nonspecific dermatitis and paralesional IF-study was negative.

Two years later, numerous seborrheic keratosis lesions and skin tags causing functional disadvantages were detected and treated with liquid nitrogen. A few benign capillary hemangiomas were not treated.

At control and follow-up for melanoma in Jan 2022, no melanoma recidives were detected, but lichen planus lesions in lower legs were treated with clobetasol and betamethasone cream. Also, the skin was found rather dry, thus, asteatosis cutis diagnosis was set, without any evidence for atopy. Later follow-up until Feb 2025 has revealed no new malignancies.

Case 4

A male born in 1956 having a Type 2 diabetes treated with insulin and hypertonia, was sent in June 2015 to Dermatology clinic by a GP referral due to severe scaly psoriasis vulgaris. Due to heavy alcohol use, he had had numerous pancreatitis episodes. PASI was 10.8.

The patient was decided to be treated by topical treatment by 3% salicylic acid - 0.05% betamethasone ointment with sun bathing.

At control 5 months later, his alcohol consumption was decreased, thus acitretin 25 mg daily was started with frequent laboratory value follow-up. At control 4 months later, acitretin was found to give first a good response. However, acitretin was later stopped due to loss of efficacy and increased Alat value and narrowband UVB therapy was started in Sept 2016, but after the first dose, a blistering dermatosis was detected at inner thighs.

Skin biopsies from right lower extremity was taken: histology revealed bullotic dermatosis and IF-study showed typical features for pemphigoid. Further treatments in Nov 2016 included oral prednisolone 10 mg daily with calcium/D-vitamin substitution and topical clobetasol or methylprednisolone aceponate crem or 3 % salicylic acid - 0.05% betamethasone ointment. After 9 months, some psoriatic plaques were detected but no signs for pemphigoid. Three months later Prednisolon was decreased to 7.5 mg/day. The patient had stopped oral prednisolone in Dec 2018 due to increase in blood sugar level, without relapse of pemphigoid.

At control in Aug 2020, skin erythrodermia with itch was noted and oral prednisolone 10 mg daily was started. A month later erythrodermia level was markedly decreased and prednisolone was continued by 5 mg/day. At control 2 months later, a relapse in erythrodermia was treated by prednisolone 7,5 mg daily. Slowly situation went better on March 2021.

A relapse in erythrodermia was noted in Nov 2021. Prednisolone 7,5 mg daily and calcipotriol-betamethasone foam were used for treatment. At control 3 months later in Feb 2022, erythrodermic skin area was 99%. Prednisolone dose was same and metotrexate 10 mg/wk with 5 mg folic acid was initiated. At control 3 months later, no clear response was noted, methotrexate was increased to 15 mg/wk and prednisolone was continued by 5 mg/day for a few months. Antihistamines gave some relief for itch.

In June 2022, erythrodermia continued, thus rizankizumab (Skyrizi) was started with standard protocol, but after 2 doses, no clear response was found, but continued for additional 2 doses (6 months), Pemphigoid antibodies were negative. The erythrodermia continued, thus, at control in May 2023 rizankizumab was changed to bimekizumab (Bimzelx), giving a clear response, as noted in control in Aug 2024. Three control biopsies from different locations revealed mild unspecific dermatitis without signs for T-cell lymphoma.

Discussion

At the first dermatologist appointment, also other diagnosis can be found that need even immediate attention, like melanoma.

By another author experience (RJH, unpublished results about 20 years ago), a GP's paper referral for excision of right scapula

nodular basalioma was directly scheduled to the operation room; however, it was found 3 other nodular basaliomas on the back skin, but also a melanoma in the middle of back between scapulas about 7 cm apart from the nodular basalioma that was originally sent for referral; all 5 lesions were removed at the same appointment session.

Also new skin disorders or the older disease can appear or reactivate during controls and follow-ups and disease can convert to another type, like plaque psoriasis to erythrodermic form as difficult to treat. When the patients get older, the risk for malignancies increase, as seen also in North-Savo Skin Cancer Project; new skin malignancies may develop in risk patients (data not shown).

It is crucial to make a careful evaluation and inspection each time when the patient is in front of a doctor, whether dermatologist or GP. After the patient has got the skin disease diagnosis by a dermatologist, the patient often is transferred to GP's follow-up. Further consultations may be performed by teledermatology[3] or by modern internet-based communication methods as WeChat[4]. The use of Artificial Intelligence is a growing area which may be beneficial to improve diagnostic accuracy in a dermatologist's hands.

Ethical Approval

The patients have given their consent for this case report.

Conflict of Interest

Authors declare no conflicts of interests.

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