Letter to the Editor

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Pityriasis rosea: Exacerbation with Corticosteroid Treatment

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Pityriasis rosea (PR) is a typical eruption [3, 6] localized on the trunk and proximal parts of the extremities. Itching is generally absent and the lesions spontaneously disappear within 4–7 weeks. Distal localization has been reported [2, 6]. The etiology remains uncertain [1, 4, 5, 7, 8]. 13 patients who had previously been treated with corticosteroids (Cs) were attended to at the Policlínico Ferroviario. Another 5 patients with typical PR were treated with Cs to observe the behavior of the eruption.

The exacerbation after intake of Cs was generally evident. In the mildly aggravated cases the impairment consisted only of a slight increase of itching, or a minimum increase in the number or irritation of the lesions. In the severe cases the exacerbation was shown by pronounced itching, increase in the number of lesions, irritation of the same, appearance of small papules, involvement of acral areas and prolongation of the disease. Urticarial and purpuric eruptions were also seen.

6 patients with severe PR underwent biopsies. The findings were similar to those of PR, but were more marked. The treatment of the exacerbated cases consisted in the discontinuation of the Cs, administration of antihistaminics and the use of mild soap. The orally administered Cs were either triamcinolone acetonide 8–24 mg daily or combined Cs with antihistaminics. 3 patients were given dexamethasone 4–8 mg daily combined with cypro-heptadine. The longer the administration of C, the longer the exacerbation. After discontinuing the C, improvement was evident; lesions and itching decreased rapidly.

The exacerbation did not occur in all the cases treated with Cs. It seemed that worsening was more marked in those patients who had received the C since the beginning of the eruption and in larger doses. Exacerbation due to

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topical Cs was rare. The onset, typical of PR, the presence of definite PR lesions, and the history of Cs intake, helped to determine the diagnosis. The adverse effects of Cs in PR treatment point to a viral etiology, and do not support an allergic or immunologic origin for PR.

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