

CASE 33-1

A 31-year-old man presents with persistent plaques on the wrists, palms, and penis. The lesions are asymptomatic and have been present for 5 months. These have not resolved with twice-daily application of hydrocortisone 1% cream.



He appears distraught and reports that this rash is “ruining his life.” He is employed as a server in an upscale restaurant, but fears that he may lose his job because several coworkers and customers have expressed concern that the rash is contagious. His boss now requires him to wear gloves at all times while at work. His girlfriend refuses to speak to him after noticing similar smaller bumps located on his penis. She is convinced that he has syphilis and questions his fidelity. He has become extremely self-conscious and reports having a depressed mood.

Based on the classical clinical appearance of these plaques, you suspect that he has psoriasis.

What is the best initial step in establishing a diagnosis?

- (A) Punch biopsy of a representative lesion on the hand or wrist
- (B) Shave biopsy of a lesion on the penis
- (C) Thorough cutaneous examination
- (D) HLA testing
- (E) Obtain plain films of his hands to evaluate for signs of psoriatic arthritis and/or bone changes

The correct answer is (C), thorough cutaneous examination.

Classic psoriasis vulgaris can be diagnosed clinically. A thorough cutaneous examination is the most appropriate answer choice. Particular attention should be used to evaluate other anatomic locations typically affected by psoriasis. For example, the clinician should examine the scalp, postauricular sulcus, the external ear, fingernails, toenails, lumbosacral region, gluteal cleft, umbilicus, and genitalia. The presence of psoriatic changes in these locations may help solidify the diagnosis. Although not included within the answer choices, obtaining an accurate history is very important as well. Particular attention should be given to family history, symptoms, social history including impact of the disease on quality of life, medications, and a review of systems. Finally, every patient with psoriasis should be screened for joint disease and enthesitis (inflammation of the tendon insertions).

A punch or shave biopsy is often useful in confirming the diagnosis when physical examination is otherwise equivocal, for an atypical presentation or disease course, or when the lesions do not respond to appropriate therapy.

Certain HLA types are associated with psoriasis. However, HLA testing is not routinely performed to establish a diagnosis of psoriasis. The presence or absence of associated HLA genotypes may provide some prognostic information, but is unnecessary to make the diagnosis and would unlikely alter management.

Imaging studies in conjunction with a thorough history and physical examination and other lab tests are useful and necessary for the work-up of psoriatic arthritis. However, in the presence of psoriatic skin lesions, it is initially more important to confirm the diagnosis of psoriasis prior to further work-up for joint and bone involvement. But keep in mind that in a minority of patients the onset of joint symptoms precedes cutaneous manifestations.