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Pityriasis Rosea Gibert - Disease History and New Findings

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Abstract: The author's aim in this article is to describe a common exanthematic disease typical of adolescence, pityriasis rosea Gibert, in the light of new findings. Another aim is to draw attention to an overlooked fact about the difficulty and inconsistency of therapy with the recommended course of action. The author uses his own experience from his many years of dermatological practice and adds facts from current literature sources on the disease. The meaning of the disease name is explained and the historical implications of the disease name are clarified. The current view of its probable viral etiopathogenesis and its similarity to another exanthematous skin disease, exanthema subitum, are described. The prodromal stage of the disease and the clinical picture of the skin findings with characteristic seeding of lesions resembling "Christmas tree branches" are described. The author's clinical pictures of the findings in individual patients with this disease are included. The possible relationship with COVID-19 is noted. The differential diagnosis is discussed, including the similarity to secondary syphilis, and the uncharacteristic histopathological picture of the disease is described. Finally, treatment options are discussed, with the caveat that the very common use of topical corticosteroids is not very effective and rather non-corticoid external therapy is recommended. The author draws attention to the possible alteration of the psychological state of predominantly adolescent patients due to the frequent long persistence of cutaneous, and therefore visible, symptoms.

Keywords: Pityriasis Rosea, HHV-6, HHV-7

1. History

The disease was first described and named in 1860 by the famous French dermatologist Prof. Camille-Melchior Gibert [1].

Prof. Camille-Melchior Gibert (*September 18, 1797 in Paris - †July 30, 1866 in Paris) was a French dermatologist, born in Paris. He studied medicine in Paris, where he worked as an intern for Laurent-Théodore Biett at the Hôpital Saint-Louis in 1818-19. In 1822 he obtained his doctorate in medicine and in 1826 he was certified in dermatology. From 1836 he was a physician at the Hôpital Lourcine and from 1840 to 1863 he was attached to the Hôpital Saint-Louis. In 1847 he became a member of the Académie de médecine. He died during the Paris cholera epidemic of 1866.

Gibert (Figure 1) became famous for the first accurate description of a papulosquamous skin disease, which he named pityriasis rosea. Historically, this disease was also referred to as "Gibert's disease". His best written work on skin diseases was the book 'Traité pratique des maladies spéciales de la peau', published in 1840.

The name of the disease pityriasis rosea aptly describes its clinical picture. Pityron means bran in Greek, a reference to the scales of peeling skin. The Latin word roseus means pink (note: latin.rosa - rose). A loose translation into English is therefore pink scales [1]. Traditionally, the third word in the name of the disease is "Gibert" in honour of its discoverer.

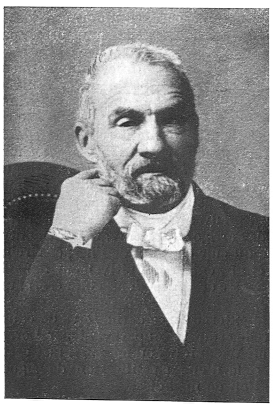

Figure 1. *Prof. Camille-Melchior Gibert.*

2. Definition

It is a common acute inflammatory dermatosis with a sowing of symmetrically, morphologically very typically arranged erythemato-squamous efflorescence, which occur mainly on the trunk.

3. Aetiology and Pathogenesis

It probably arises as an "id" type reaction to some viral infections (probably HHV-7) [2, 3]. The disease has a peak incidence in spring and autumn. It is most common in people between 10-35 years of age [4].

HHV-6 and HHV-7 belong to the family Herpesviridae. Primoinfection with HHV-6 usually takes place in childhood, and often occurs without symptoms or causes one of the most well-known manifestations of these viruses - a non-serious febrile state in infants and young children with exanthema subitum (the so-called sixth childhood disease). HHV-7 also causes very similar symptoms in adolescents. It is possible to believe that pityriasis rosea Gibert is a similar or identical type of disease, but at an older age. The higher incidence of both diseases in collectives suggests an infectious aetiology, supporting the theory of a viral aetiology [4].

After the disease, patients acquire lifelong immunity [3].

4. Clinical Picture

The disease is preceded by a prodromal stage characterized by fatigue, subfebrile headache, muscle aches, and nasopharyngitis. Afterwards, the so-called primary macule (Figure 2) (also called the maternal lesion or heraldic macule) develops - an oval pityriasis-form exfoliating lesion 2-5 cm in diameter, usually on the abdomen or trunk. Within 1-2 weeks, similar but smaller foci typically arranged along the lines of skin cleavage, especially on the trunk and proximally on the extremities in embolization localization), develop. Seeding in the lines resembles "Christmas tree branches" when viewed on the patient's back (Figure 3). In my dermatological practice I often see this typical picture and it helps to diagnose the disease confidently and quickly.

Figure 2. *Pityriasis rosea Gibert – primary macule (author's archive).*

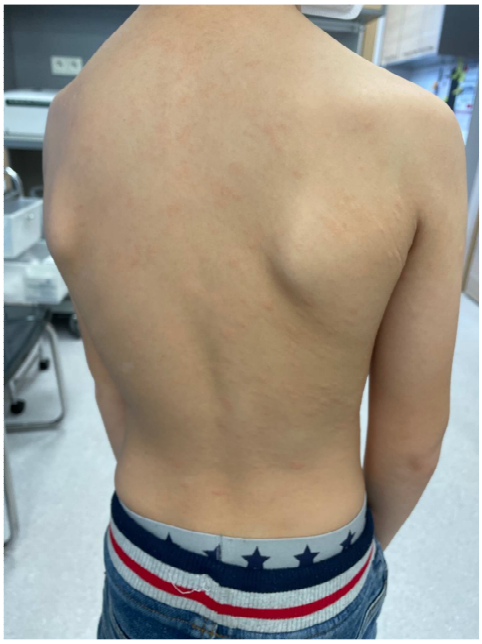

Figure 3. *Pityriasis rosea Gibert – clinical picture of the "Christmas tree" (author's archive).*

Also typical is the collar-like (so-called collerette) pityriasis-form exfoliation of the lesions. The exanthema may be itchy, and I have encountered agonizing pruritus in some patients.

After healing, post-inflammatory hypopigmentation or hyperpigmentation (lighter or darker patches of skin) may be seen, which disappear over the following weeks to months.

A so-called inverse form occurs relatively often in children. It manifests in the axillae and the groin area. Spot-like haemorrhages, erosions or minor ulcerations may occur on the cheeks, in the capillary and in the oral cavity [6]. The disease occurs opportunistically in HIV patients, as a result of a compromised immune system [7]. Pityriasis rosea-like manifestations were observed during the pandemic in COVID-19 positive patients [8].

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5. Diagnosis

A typical clinical picture of the disease, such as primary "maternal" plaque with gradually developing exanthema on the trunk with erythemato-pityriasiform foci without manifestations on the oral mucosa, is sufficient to establish the diagnosis. Arrangement of efflorescences in the splitting of the skin. The general physical condition is not altered [1].

6. Differential Diagnosis

Includes secondary stage syphilis, tine corpora, pityriasis versicolor, pityriasis lichenoides chronica, psoriasis, drug rashes (ex. barbiturates, ACE inhibitors) and seborrheic dermatitis [4, 6, 14]. In manifestations with vesicles and

pustules, we also have to consider erythema multiforme in differential diagnosis [9].

Serology will confirm the ruling out of syphilis. A native lye preparation examination, which will be negative, can be conducted to differentiate it from a mycotic disease. A skin biopsy can be performed to clarify a definitive diagnosis. Histopathology is not specific, with edema in the stratum papillary, there is mild spongiosis in the epidermis, spotted parakeratosis occurs in the stratum corneum [1].

7. Therapy

Although the skin manifestations heal spontaneously, the healing time can be very long, even in the order of months. A persistent seeding of the entire body lasting up to half a year is not an exception, which also brings psychological alteration (Figures 3, 4). Patients are often ashamed of their manifestations because the environment wrongly concludes the infectious nature of the seeding. Social isolation occurs. Also, the prolonged pruritus that occurs in some patients is bothersome and needs to be alleviated. It is advisable to soothe the manifestations and accelerate their healing with anti-inflammatory, preferably non-corticoid substances such as ichthammol [5, 15] (e.g., Cutozinc® Ichthamo spray or pix. Corticoids used externally are not very effective [1]. Efflorescence are prone to irritation after washing with common soaps and shampoos [4-6]. At the time of illness, only mild, non-irritating, sulphate-free syndettes [10], (e.g., Cutosan® washing gel) are recommended for hygiene, which can be used on the body and scalp. Therapeutic procedures include UVB phototherapy [11]. High-dose therapy with 5x 800mg of acyclovir daily for a period of 7 days is also possible [12]. There are several studies dealing with the effectiveness and usefulness of treatment that demonstrate the beneficial effects of macrolide antibiotics, especially erythromycin (250mg four times per day, which significantly shortened the duration of skin lesions) [13]. Patients are advised to wear 100% cotton, loose-fitting, breathable clothing.

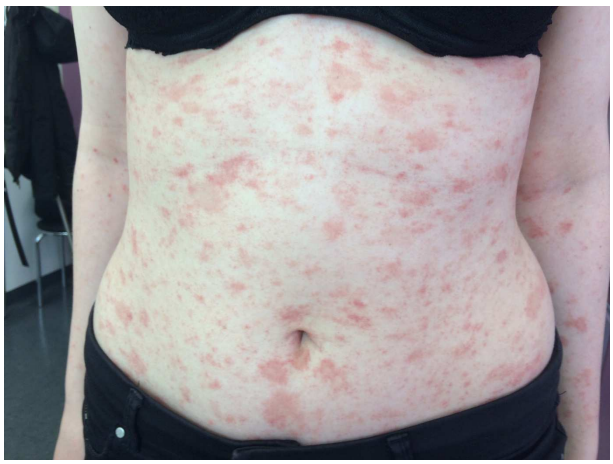

Figure 4. *Pityriasis rosea Gibert – extensive, irritated lesions (author's archive).*

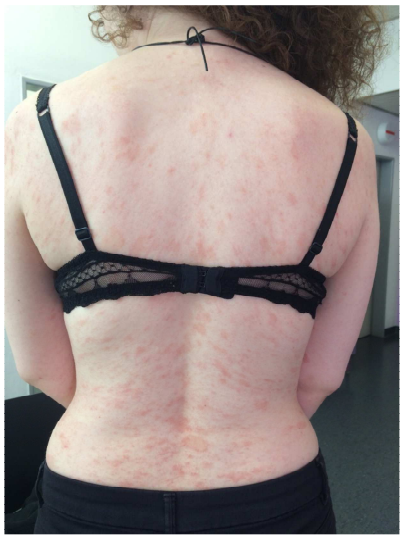

Figure 5. *Pityriasis rosea Gibert – extensive, long-lasting sowing (author's archive).*

8. Conclusion

Pityriasis rosea Gibert is a disease that predominantly affects young people. Despite spontaneous healing, due to the frequent prolonged duration of the disease, patients need to be treated. The aim is to alleviate the subjective discomfort, shorten the duration of the symptoms and thus prevent a negative impact on the psyche.

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