Answer to Dermacase *continued from* **page 199**

3. Confluent and reticulated papillomatosis

Confluent and reticulated papillomatosis (CARP), otherwise known as *Gougerot-Carteaud syndrome*, was first reported by Henri Gougerot and Alexandre Carteaud in 1927.[1] It is an uncommon dermatosis and presents clinically as small, erythematous macules and papules that can evolve into hyperkeratotic, verrucous plaques.[1-3] Confluent and reticulated papillomatosis spreads centrifugally, leading to confluent lesions at the midline and reticulated ones at the periphery. This condition is more common among black women in their second or third decade and usually affects the neck, interscapular area, abdomen, and intermammary space.[2,3] Although a few familial cases have been reported, most occurrences of CARP are sporadic. Histology commonly reveals hyperkeratosis, papillomatosis, mild acanthosis, basal cell pigmentation, and a mild superficial perivascular inflammatory cell infiltrate[2,3]—findings similar to the ones revealed after a biopsy of our patient's lesions. Results of potassium hydroxide smear tests, mycological and bacterial cultures, and examination under Wood light are usually negative, as was the case with our patient.[2,3]

Pathogenesis is still unclear, but several theories have been proposed: keratinization disorder, abnormal host reaction to fungus, photosensitivity, endocrine abnormalities, or genetic predisposition. The first 2 explanations are the ones most generally accepted.[2,3]

Differential diagnosis

The clinical differential diagnosis of CARP should include acanthosis nigricans, tinea versicolor, and macular amyloidosis.[4-6] Acanthosis nigricans, commonly observed in obese, darkly pigmented individuals, characteristically presents as velvety hyperpigmentation of the intertriginous areas.[4] Tinea versicolor is a superficial fungal infection of the skin caused by *Malassezia* yeast species.[5] It is characterized clinically by multiple asymptomatic, round to oval, slightly scaly patches that might be hyperpigmented or hypopigmented. The lesions usually favour seborrheic areas, especially the upper trunk and shoulders, although they can at times be quite extensive.[5] In difficult cases, the diagnosis can be established by shining a Wood lamp over the affected area (which will reveal bright yellow fluorescence in positive cases) or by examining a skin sample under a microscope using a potassium hydroxide preparation. Macular amyloidosis often presents as pruritic hyperpigmented patches in a confluent or rippled pattern on the upper back of young adults, especially women.[6] On histology, amyloid deposits are usually observed in the upper dermis.

Management

The treatment of CARP is usually difficult.[2,3] Variable results have been encountered with different topical preparations including calcipotriol, miconazole, and selenium sulfide. Some oral antibiotics have been reported to be effective, mainly minocycline but also azithromycin, clarithromycin, and erythromycin. Other treatments including cryotherapy, retinoids, phototherapy, radiotherapy, and dermabrasion have been documented in anecdotal case reports as beneficial. Our patient was prescribed oral minocycline (200 mg daily) and his symptoms resolved after 3 weeks of therapy.

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Competing interests
None declared

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