

Case Report

Blaschkoid Pityriasis Rosea on Trunk and Upper Limb of an Adult Male - A Case Report

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ABSTRACT

Pityriasis rosea (PR) is a common self-limiting papulosquamous disorder, and its atypical variants, including the Blaschkoid type, are rare and may mimic other linear dermatoses, leading to diagnostic difficulty. We report an 18-year-old male who developed mildly pruritic erythematous papules and plaques arranged strictly along Blaschko's lines on the right side of the trunk, upper arm, forearm, and palm, preceded by a herald patch. Histopathological examination was consistent with PR. A diagnosis of unilateral Blaschkoid PR was made, and the patient responded well to topical corticosteroids and antihistamines, achieving complete resolution within three weeks without relapse. This case highlights a rare unilateral Blaschkoid variant with simultaneous trunk and upper-limb involvement, emphasizing the importance of recognizing atypical presentations to avoid misdiagnosis and unnecessary interventions.

Keywords: Atypical variant, Blaschkoid, Pityriasis rosea, Trunk and upper limb

INTRODUCTION

Pityriasis rosea (PR) is a prevalent papulosquamous disorder that typically presents with a herald patch followed by erythematous plaques with a collarette of scales. They are distributed over the trunk in a Christmas tree pattern. However, there are various atypical patterns, of which the Blaschkoid pattern is quite rare. We describe a case of unilateral Blaschkoid PR involving both the trunk and ipsilateral upper limb, a distribution rarely reported in adults. In the absence of recent viral infections or drug intake, it is important to recognise such rare variants as they pose a diagnostic challenge, requiring careful clinical examination and consideration of differential diagnoses.

CASE REPORT

An 18-year-old male presented with mild itchy lesions on the right side of the chest and few scattered lesions over the arm. Over the next 1 week, he noticed an increase in the number and extent of lesions over the right upper limb, till the forearm and few over the right palm. No history of any prodrome or drug intake before the onset of these lesions. Dermatological examination revealed a herald patch on the right side of the trunk [Figure 1]. Later, multiple

erythematous papules and plaques with mild scaling were seen in a whorled pattern on the right side of the chest extending to the upper limb in a linear pattern along the Blaschkoid lines [Figure 2]. Based on the history, onset and distribution of lesions, differential diagnoses of Blaschkoid PR and adult blaschkitis were considered. His Venereal Disease Research Laboratory (VDRL) was non-reactive and human immunodeficiency virus antibody was negative. Histopathological examination revealed a mound of parakeratosis, intraepidermal spongiosis and perivascular lymphomononuclear infiltrate with extravasated red blood cells [Figure 3]. A diagnosis of Blaschkoid PR was made based on clinicopathological findings. His lesions resolved completely over 3 weeks with topical corticosteroids and antihistamines. Six months of follow-up revealed no relapse.



Figure 1: Herald patch on right side of chest (closer view shown with arrows on the right) with few lesions on the arm.



Figure 2: Erythematous plaques with mild scaling seen over (a) The right side of chest, right arm, forearm; (b) Back and (c) The palm along the blaschkoid lines.

DISCUSSION

PR is a self-limiting eruption distributed symmetrically along the Langer's lines of cleavage.^[1] Up to 20% of patients can have atypical morphological variants such as papular, vesicular, follicular, urticarial and distributional variants such as acral, inverse, unilateral and Blaschkoid,^[2] which mimic other dermatoses, thus leading to diagnostic uncertainty. Blaschkoid PR is a rare variant with unilateral distribution along the lines of Blaschko rather than Langer's lines. Acquired Blaschkoid dermatoses have been attributed to cutaneous mosaicism.^[3] Grosshans proposed that such a localised acquired Blaschko-linear distribution of an otherwise generalised dermatoses could be the result of unmasking of the hidden abnormal keratinocyte clones along these developmental pathways by triggers such as viral infection, vaccination, or an immune alteration.^[3] In a systematic study of 507 patients with PR, Blaschkoid PR accounted for only 0.59%.^[4] The lesions are arranged in linear, S-shaped, or whorled configurations on the trunk or limbs.^[2,3] The etiopathogenesis is thought to involve reactivation of human herpesvirus-6 and -7, supported by detection of viral Deoxy ribonucleic acid (DNA) and Ribonucleic acid (RNA) in lesional skin, saliva and peripheral blood.^[1] Polymerase chain reaction for demonstration of viral trigger was not done in view of poor resource settings and absence of prodrome. PR and its atypical forms following COVID-19 vaccination^[5] suggest that immune stimulation may unmask latent viral infections and trigger Blaschkoid lesions.^[2] In our patient, there was no such known prodrome, in which case there could have been a subclinical trigger or immune alteration that cannot be proved. The benign course of spontaneous remission, histopathology and management are the same in both Blaschkoid and classical PR.^[4,5] The linear Blaschkoid distribution of PR necessitates the differentiation from other common acquired blaschkolinear dermatoses [Table 1]. In our case, the presence of a herald patch, collarette scaling, typical papulosquamous morphology, unilateral lesions strictly along Blaschko's lines and histopathology strongly favoured the diagnosis of Blaschkoid PR. Only a handful of adult cases of Blaschkoid PR have been documented. Ang has reported a unilateral Blaschkoid PR involving the left leg and arm in a female, preceded by pharyngitis with spontaneous resolution.^[6] Zawar described three cases of Blaschkoid PR in the lower limb among 507 cases of PR.^[4] Symmetric Blaschkoid PR on the trunk in a child with type 1 diabetes has been described.^[7] The distinctiveness of our case lies in the simultaneous involvement of both the trunk and the ipsilateral upper limb, a distribution pattern seldom reported in adults. The case report contributes to expanding the documented clinical spectrum of Blaschkoid PR.

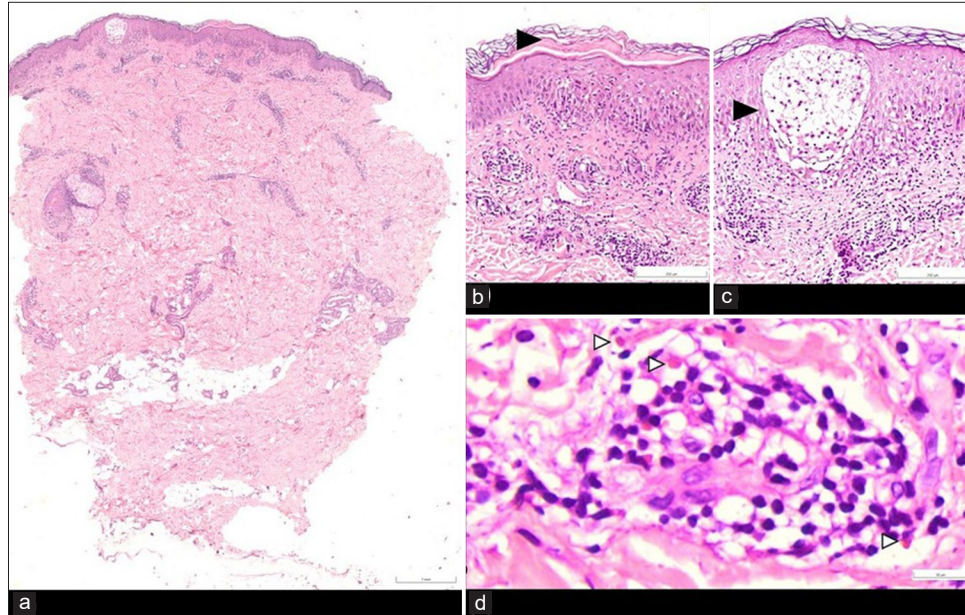


Figure 3: Histopathology: (a) $\times 20$ magnification, haematoxylin and eosin (H&E) stain: Skin biopsy with epidermis, dermis and part of the subcutis, (b) $\times 100$ magnification, H&E stain; Epidermis with a mound of parakeratosis (black arrowhead) with lymphocytic exocytosis, (c) $\times 100$ magnification, H&E stain: Epidermis with an intraepidermal spongiotic vesicle (black arrowhead), (d) $\times 400$ magnification, H&E stain; Upper dermal capillary showing perivascular lymphomononuclear cell infiltrate with extravasated red blood cells (white arrowheads).

Table 1: Differential diagnosis of Blaschkoid PR.

Feature	Blaschkoid PR	Lichen striatus	Adult blaschkitis
Age group	Adolescents, young adults	Children, young adults	Adults
Onset	Herald patch, followed by multiple lesions	Sudden onset, single linear band	Insidious
Lesion morphology	Papules/plaques with collarette scale	Flat-topped papules along single line	Papules/vesicles along multiple lines
Histopathology	Focal mound of parakeratosis, spongiosis, RBC extravasation, exocytosis of lymphocytes	Focal hyperkeratosis, parakeratosis, mild acanthosis, basal cell vacuolisation, apoptotic keratinocytes. Lichenoid infiltrate at the dermoepidermal junction, perivascular and periappendageal (eccrine glands- a hallmark feature) inflammatory infiltrates.	Spongiotic dermatitis, perivascular lymphocytic infiltrate. Lichenoid inflammation can be seen
Resolution	2–6 weeks	Months to year	1–2 months
Relapse	Less	Rare	Frequent

PR: Pityriasis rosea, RBC: Red blood cell

CONCLUSION

This case highlights the rare unilateral Blaschkoid variant of PR. Awareness of such atypical presentations is essential to prevent misdiagnosis and unwarranted interventions. Recognition of Blaschkoid PR contributes to expanding the clinical spectrum of PR and underscores the role of cutaneous mosaicism in its pathogenesis.

Ethical approval: Institutional Review Board approval is not required.

Declaration of patient consent: The authors certify that they have

obtained all appropriate patient consent forms. In the form, the patients have given their consent for their images and other clinical information to be reported in the journal. The patients understand that their names and initials will not be published and due efforts will be made to conceal their identity, but anonymity cannot be guaranteed.

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