

Reply to Letter to the Editor

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To the Editor,

We are most grateful to Drago et al. for their interest in our paper entitled "Pityriasis rosea: a natural history of pediatric cases in the Central Anatolia Region of Turkey" (1). The basic aim of our study was to examine the demographic, clinical, and epidemiological characteristics of pityriasis rosea (PR) in children (1). That is why no virological examination was performed.

While drugs, stress, pregnancy, and various infections have previously been implicated in the etiopathogenesis of PR, there has recently been focus on systemic activation of human herpes virus (HHV)-6 and HHV-7 (2-8).

Drago et al. observed that pediatric PR appeared at similar rates throughout the year (7), while we determined a higher prevalence of PR in children in winter (1). The fall in environmental temperatures may have triggered the disease by suppressing cellular immunity in susceptible individuals.

Drago et al. recorded various infections in 26% of patients before skin manifestations in pediatric PR, and drug use in 6% (7), while 32.6% of our patients had a history of upper respiratory tract infection and 32.6% a history of drug use (1). These levels were close to those reported in Gündüz et al.'s study from Turkey (9).

PR-like eruption is defined as a medication-induced cutaneous rash whose clinical characteristics are remarkably similar to those of genuine PR, and that often cannot easily be distinguished from it. However, it is exceedingly important to do so, since typical PR may occur during treatment, but independently of it. Various differentiating criteria have recently been suggested.

Clinical, histopathological, and virological investigations will certainly be useful in such differentiation (8,10). However, even if virological investigations prove to be useful in this area, they are nevertheless difficult to implement in practice. Diagnosis of PR was based on history and physical examination in the majority of our cases. However, in atypical cases, skin biopsy performed by a dermatologist was used in order to differentiate between PR and other exanthemas. Patients with indefinite diagnoses were considered for enrollment (1).

Pruritus has been reported in 25% of adult PR patients and in 69%-90% of children. The incidence of pruritus in our study was 74% (9,11,12). The incidence was higher than the general figure reported for adults, but similar to previous studies involving pediatric populations (1,9,11,12).

Drago et al. observed oral involvement in 35% of children with PR (7), while Amer et al. determined no oral lesions in children of Afro-American origin (11). We also observed no oral lesions in our patients (1). This suggests that socioeconomic status and genetic factors may be involved in the course of PR.

In conclusion, PR exhibits a similar course in children and adults in Turkey. We observed a higher incidence of disease during the rainy and snowy months. Upper respiratory tract infection was determined prior to rash in 32.6% of our subjects. The high prevalence of pruritus also constituted a significant finding, but this quickly resolved. Further studies involving larger patient numbers are now needed to compare PR symptoms between different age cohorts and ethnic groups.

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