International Journal for Multidisciplinary Research (IJFMR)
E-ISSN: 2582-2160 ● Website: www.ijfmr.com ● Email: editor@ijfmr.com

Beyond the Herald Patch: Clinicohistological Correlation of Clinical Variants of Pityriasis Rosea

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Abstract

Background: Pityriasis rosea (PR) is a common acute papulosquamous disorder characterized by a classical presentation as well as several atypical clinical variants. Atypical presentations may create diagnostic difficulty and may require histopathological assessment for differentiation from other papulosquamous disorders. This study evaluated the clinical spectrum and clinicohistological features of PR.

Methods: A cross-sectional observational study was conducted among 40 patients clinically diagnosed with PR. Demographic and clinical characteristics, including age, sex, disease duration, pruritus, prodromal symptoms, herald patch, Christmas-tree pattern, and clinical variant, were recorded. Patients were categorized into classical and atypical PR groups. Histopathological examination was performed in clinically indicated cases, particularly atypical presentations, and the microscopic findings were correlated with the clinical diagnosis.

Results: The mean age of participants was 23.6 ± 10.1 years, with males comprising 55.0% of the cohort. Classical PR was observed in 25 (62.5%) patients, while 15 (37.5%) had atypical PR. Among atypical cases, papular and inverse PR were the most frequent variants (40.0% each). Pruritus was present in 87.5%, a herald patch in 60.0%, and a Christmas-tree pattern in 67.5% of patients. No statistically significant differences were observed between classical and atypical PR regarding age, disease duration, herald patch, Christmas-tree pattern, pruritus, prodromal symptoms, or drug history ($p>0.05$). Histopathology predominantly demonstrated spongiosis, parakeratosis, superficial perivascular lymphocytic infiltration, and erythrocyte extravasation.

Conclusion: PR demonstrated considerable clinical variability, with atypical variants comprising a substantial proportion of cases. Clinicohistological correlation was particularly valuable in atypical presentations and supported accurate recognition of the diverse manifestations of PR.

Keywords: Pityriasis rosea; Atypical pityriasis rosea; Histopathology; Clinicohistological correlation; Papulosquamous disorder

1. Introduction

Pityriasis rosea (PR) is a common acute, self-limiting papulosquamous disorder of the skin characterized by the development of erythematous, oval, scaly lesions. The classical presentation usually begins with a solitary larger lesion known as the herald patch, followed after an interval by multiple smaller secondary lesions that are predominantly distributed along the cleavage lines of the trunk, producing the characteristic "Christmas tree" pattern [1]. The condition commonly affects children, adolescents, and young adults and generally resolves spontaneously within several weeks. Although the precise etiopathogenesis remains incompletely understood, viral reactivation, particularly involving human herpesvirus-6 and human herpesvirus-7, has been proposed as an important mechanism. Other possible precipitating factors include infections, vaccinations, medications, and immunological responses [2].

The diagnosis of classical PR is predominantly clinical and is usually based on the characteristic morphology and distribution of lesions. However, clinical recognition becomes considerably more difficult when patients present with atypical forms. Histopathological examination is not routinely required in typical cases but may become important when the clinical presentation is unusual or when other papulosquamous disorders need to be excluded. Conditions such as psoriasis, pityriasis lichenoides, secondary syphilis, dermatophytosis, drug eruptions, and other inflammatory dermatoses may closely resemble PR clinically. Histopathological examination may demonstrate variable but characteristic features, including focal parakeratosis, spongiosis, acanthosis, extravasation of erythrocytes, and a superficial perivascular lymphocytic infiltrate. Although these findings may not be pathognomonic individually, their interpretation in conjunction with clinical findings can strengthen diagnostic confidence [3].

A wide spectrum of clinical variants of PR has been described, reflecting considerable heterogeneity in morphology, distribution, and clinical course. These include inverse, papular, vesicular, purpuric, urticarial, localized, giant, unilateral, and other unusual forms [4]. Such variants may lack the classical herald patch, demonstrate an unusual distribution, or exhibit morphology that overlaps with other inflammatory and papulosquamous diseases. Consequently, atypical PR may be associated with diagnostic uncertainty, delayed recognition, unnecessary investigations, and inappropriate treatment. Recognition of these variants is therefore important for dermatologists, particularly in tertiary care settings where patients with unusual or diagnostically challenging presentations are frequently encountered [5].

Clinicohistological correlation assumes particular importance in atypical PR. Assessment of the patient's age, duration of disease, lesion morphology, distribution, presence or absence of a herald patch, associated symptoms, and potential preceding infections provides the clinical framework for diagnosis. Histopathological evaluation can then provide additional information regarding epidermal and dermal changes and help distinguish PR from clinically similar conditions. Previous investigations have demonstrated inflammatory infiltrates and epidermal alterations in both herald and secondary lesions, supporting the contribution of cell-mediated immune mechanisms to the disease process [6]. Histopathological assessment has also demonstrated variable combinations of spongiosis, parakeratosis, acanthosis, and perivascular inflammatory infiltrates in affected patients [7].

Recent clinical and histopathological studies further emphasize the importance of evaluating atypical PR systematically. A substantial proportion of patients may present with atypical variants, with

histopathological findings including spongiosis, parakeratosis, irregular acanthosis, perivascular lymphocytic infiltration, and erythrocyte extravasation [8]. Immunohistochemical investigations have also explored markers that may assist in differentiating PR from important mimickers such as psoriasis and pityriasis lichenoides [9]. Furthermore, unusual presentations such as an isolated herald patch have been investigated as possible abortive forms of PR, demonstrating that the clinical spectrum may extend beyond the conventional sequence of herald patch followed by generalized secondary eruption [10].

Despite the well-established recognition of classical PR, atypical clinical variants remain less comprehensively characterized, particularly with regard to their corresponding histopathological features. There is also limited region-specific evidence evaluating the relationship between clinical morphology and microscopic findings across the different variants. A systematic clinicohistological assessment may therefore improve understanding of the heterogeneous presentation of PR and clarify the diagnostic contribution of histopathology in atypical cases. Correlating clinical findings with histopathological features may assist in distinguishing PR from its mimickers, reducing diagnostic uncertainty and avoiding unnecessary investigations or inappropriate treatment. Therefore, the present study will evaluate the spectrum of classical and atypical clinical variants of pityriasis rosea and assess their clinicohistological correlation among patients attending a tertiary care hospital.

2. Methdology

2.1 Study Design

The study was conducted as a cross-sectional observational clinicopathological study.

2.2 Study Setting

The study was conducted in the **Department of Dermatology of a tertiary care hospital**.

2.3 Study Duration

The study was conducted during the **specified study period**, and eligible patients presenting during this period were enrolled consecutively.

2.4 Participants – Inclusion and Exclusion Criteria

Inclusion criteria:

- Patients of any age and either gender with a clinical diagnosis of pityriasis rosea were included.
- Patients presenting with classical or atypical clinical variants of pityriasis rosea were included.
- Patients who were willing to provide written informed consent were included.
- For minor participants, assent along with parental or guardian consent was obtained.
- Patients undergoing skin biopsy whenever clinically indicated were included for histopathological assessment.

Exclusion criteria:

- Patients diagnosed with papulosquamous disorders other than pityriasis rosea were excluded.
- Patients who had received treatment likely to significantly alter the clinical or histopathological findings before evaluation were excluded.
- Patients unwilling to participate or unwilling to provide informed consent were excluded.
- Patients with inadequate clinical records were excluded.
- Biopsy specimens that were inadequate or of poor quality for reliable histopathological interpretation were excluded from clinicohistological correlation.

2.5 Study Sampling

Consecutive sampling was used for participant recruitment. All patients who fulfilled the eligibility crite-

ria and presented to the Department of Dermatology during the study period were assessed for participation. Eligible patients who provided informed consent were enrolled consecutively until the desired sample size was reached. This approach enabled recruitment of patients presenting with different clinical forms of pityriasis rosea without deliberately selecting particular variants. Histopathological evaluation was performed only in patients in whom biopsy was clinically indicated, particularly in atypical presentations or when confirmation of the diagnosis was required.

2.6 Study Sample Size

The study included approximately **40 patients** with clinically diagnosed pityriasis rosea. As the study was observational and descriptive in nature, patients presenting during the study period were enrolled consecutively until approximately 40 cases were obtained. Histopathological examination was not planned for every participant because skin biopsy was performed only when clinically indicated as part of routine clinical management or for diagnostic confirmation. Therefore, clinicohistological correlation was performed using all available biopsy specimens obtained from the enrolled participants.

2.7 Study Parameters

The study parameters included demographic, clinical, dermatological, and histopathological characteristics. Demographic parameters included age and gender. Clinical parameters included duration of disease, presence or absence of a herald patch, lesion morphology, distribution, number and size of lesions, presence of scaling, pruritus, associated symptoms, preceding upper respiratory tract infection, drug history, past history, family history, and the provisional clinical diagnosis. Dermatological examination included assessment of mucosal, palmoplantar, and nail involvement. Histopathological parameters included hyperkeratosis, parakeratosis, spongiosis, acanthosis, exocytosis, erythrocyte extravasation, superficial perivascular lymphocytic infiltrate, dermal edema, and other relevant microscopic features.

2.8 Study Procedure

After obtaining informed consent, each participant underwent a detailed clinical assessment. The morphology, distribution, number, size, and pattern of lesions were recorded, along with the presence or absence of a herald patch and associated symptoms. A complete dermatological examination was performed to identify mucosal, palmoplantar, or nail involvement. Clinical variants were classified based on the observed presentation. A skin biopsy was performed only when clinically indicated, particularly in atypical cases or when differentiation from other papulosquamous disorders was required. The biopsy specimens were subjected to histopathological examination, and relevant epidermal and dermal microscopic features were documented. The clinical diagnosis and histopathological findings were subsequently compared to establish the clinicohistological correlation.

2.9 Study Data Collection

Data were collected using a structured case record form. Demographic and clinical information was recorded during the dermatological evaluation. Details regarding age, gender, disease duration, preceding infection, drug exposure, symptoms, lesion morphology, distribution, and clinical variant were documented. The number, size, and sites of lesions were also recorded. Photographic documentation was performed wherever appropriate after obtaining consent. For patients undergoing biopsy, the histopathological findings were recorded systematically, including epidermal and dermal alterations and inflammatory changes. The clinical and histopathological findings were subsequently compiled for statistical analysis.

2.10 Data Analysis

The collected data were entered into Microsoft Excel and analyzed using SPSS version 26.0 or the latest available version. Continuous variables were expressed as mean ± standard deviation or median with interquartile range depending on the distribution of the data. Categorical variables were summarized as frequencies and percentages. Associations between clinical variants and histopathological findings were assessed using the Chi-square test or Fisher's exact test, as appropriate. Agreement between clinical and histopathological diagnoses was assessed using the Kappa coefficient, wherever applicable. A p-value <0.05 was considered statistically significant.

2.11 Ethical Considerations

The study was conducted after obtaining the required approval from the institutional ethics committee. Written informed consent was obtained from all participants before enrollment. For participants below the age of consent, appropriate assent and parental or guardian consent were obtained. Participation was voluntary, and participants were allowed to withdraw from the study without affecting their clinical care. Patient confidentiality was maintained throughout the study, and clinical information and photographs were used only for research purposes after appropriate consent. Skin biopsy was performed only when clinically indicated and was not undertaken solely for research purposes. All collected information was securely maintained and used exclusively for the objectives of the study.

3. Results

Table 1. Demographic characteristics of the study population (n = 40)

Variable	Frequency (n)	Percentage (%)
Age group		
<12 years	5	12.5
12–17 years	2	5.0
18–29 years	22	55.0
30–44 years	11	27.5
Gender		
Male	22	55.0
Female	18	45.0

The study included 40 patients with pityriasis rosea, with an age range of 1–42 years. The mean age was 23.6 ± 10.1 years and the median age was 21.5 years. The majority of patients belonged to the 18–29-year age group (55.0%), followed by the 30–44-year group (27.5%). Children below 12 years constituted 12.5%, while adolescents aged 12–17 years accounted for 5.0%. There was a slight male predominance, with males comprising 55.0% and females 45.0% of the study population.

Table 2. Clinical characteristics of patients with pityriasis rosea (n = 40)

Clinical characteristic	Frequency (n)	Percentage (%)
Prodromal symptoms present	6	15.0
No prodromal symptoms	34	85.0
History of drug intake	4	10.0
No drug history	36	90.0

Pruritus with red lesions	35	87.5
Red lesions without pruritus	5	12.5
Herald patch present	24	60.0
Herald patch absent	16	40.0
Christmas-tree pattern present	27	67.5
Christmas-tree pattern absent	13	32.5

Most patients (85.0%) did not report prodromal symptoms before the onset of skin lesions, while 15.0% reported symptoms such as fever, sore throat, upper respiratory tract symptoms, or gastrointestinal symptoms. A preceding history of drug intake was present in only 10.0% of patients. Pruritus accompanied by red lesions was the predominant presenting symptom, occurring in 87.5% of patients. A herald patch was clinically identified in 60.0% of cases, whereas 40.0% lacked an identifiable herald patch. The characteristic Christmas-tree distribution was observed in 67.5% of patients.

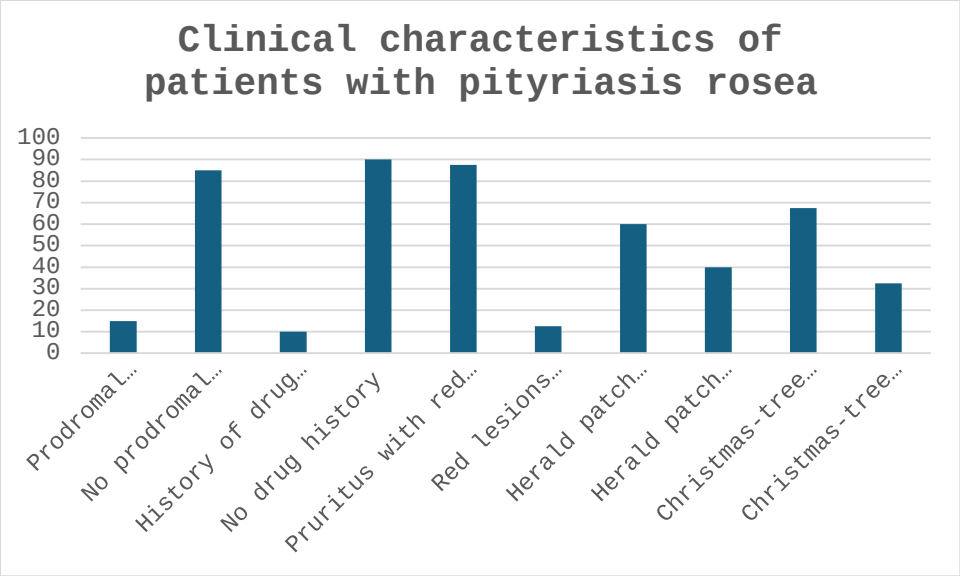


Table 3. Duration of disease at presentation (n = 40)

Parameter	**Value**
Mean ± SD	6.5 ± 5.4 days
Median (IQR)	5.0 (3.0–7.0) days
Minimum–Maximum	1–30 days
Shapiro–Wilk W	0.731
p-value	<0.001

The duration of disease at presentation ranged from 1 to 30 days. The mean duration was 6.5 ± 5.4 days, whereas the median duration was 5.0 days with an IQR of 3.0–7.0 days. The Shapiro–Wilk test showed a statistically significant departure from normality ($W = 0.731$, $p < 0.001$), indicating that disease duration was not normally distributed. Therefore, the median and IQR were considered more appropriate measures for describing the distribution of disease duration.

Table 4. Distribution of clinical variants of pityriasis rosea (n = 40)

Clinical type/variant	Frequency (n)	Percentage (%)
Classical PR	25	62.5
Atypical PR	15	37.5
Atypical variants		
Papular PR	6	40.0
Inverse PR	6	40.0
EMF-like PR	2	13.3
Excoriated papular PR	1	6.7

Classical pityriasis rosea was the predominant clinical presentation, accounting for 62.5% of the study population, whereas atypical PR constituted 37.5%. Among the 15 atypical cases, papular PR and inverse PR were equally common, each accounting for 40.0% of atypical presentations. EMF-like PR represented 13.3%, while excoriated papular PR was the least frequent variant at 6.7%. Thus, although classical PR predominated, a substantial proportion of patients demonstrated atypical clinical presentations.

Table 5. Distribution of herald patch and anatomical site (n = 40)

Parameter	Frequency (n)	Percentage (%)
Herald patch		
Present	24	60.0
Absent	16	40.0
Site of herald patch		
Upper limb	12	30.0
Trunk/neck	9	22.5
Lower limb	4	10.0
No herald patch/not applicable	15	37.5

A herald patch was present in 60.0% of patients, whereas 40.0% had no clinically identifiable herald patch. Among the documented sites, the upper limb was the most frequent location, accounting for 30.0% of the total cohort, followed by the trunk/neck region at 22.5% and the lower limb at 10.0%. The relatively high proportion of patients without a herald patch highlights the variability in clinical presentation within the study population.

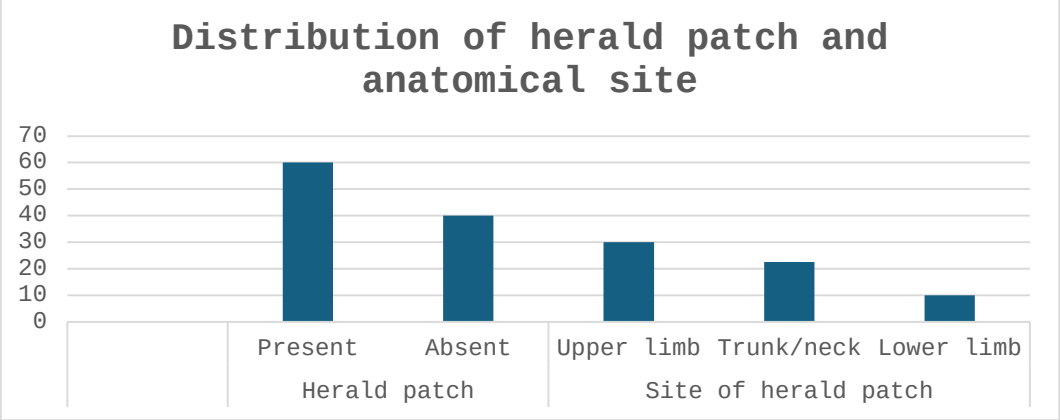


Table 6. Comparison of age and duration of disease between classical and atypical PR

Variable	Classical PR (n=25)	Atypical PR (n=15)	Statistical test	p-value
Age, mean ± SD (years)	23.4 ± 8.4	24.1 ± 12.8	Independent t-test, t = −0.21	0.834
Duration, median (IQR), days	5.0 (3.0–7.0)	5.0 (3.5–8.5)	Mann–Whitney U = 172.0	0.672

The mean age was similar between patients with classical PR and atypical PR, being 23.4 ± 8.4 years and 24.1 ± 12.8 years, respectively. This difference was not statistically significant (p = 0.834). Similarly, the median duration of disease was 5 days in both groups, with no statistically significant difference in the distribution of disease duration (p = 0.672). Therefore, within this study population, age and duration of illness were not significantly associated with the clinical type of PR.

Table 7. Comparison of categorical clinical characteristics between classical and atypical PR

Clinical characteristic	Classical PR n (%)	Atypical PR n (%)	p-value
Male sex	11 (44.0)	11 (73.3)	0.104
Herald patch present	16 (64.0)	8 (53.3)	0.527
Christmas-tree pattern present	19 (76.0)	8 (53.3)	0.175
Pruritus present	22 (88.0)	13 (86.7)	1.000
Prodromal symptoms present	4 (16.0)	2 (13.3)	1.000
History of drug intake	2 (8.0)	2 (13.3)	0.623
Biopsy performed	24 (96.0)	15 (100.0)	1.000
Dermoscopy performed	23 (92.0)	15 (100.0)	0.519

No statistically significant differences were observed between classical and atypical PR for any of the assessed categorical clinical characteristics, as all p-values were greater than 0.05. Although males constituted a higher proportion of the atypical group than the classical group (73.3% vs 44.0%), this difference was not statistically significant (p = 0.104). The presence of a herald patch, Christmas-tree pattern, pruritus, prodromal symptoms, preceding drug intake, and utilization of biopsy or dermoscopy also did not differ significantly between the two groups. These findings indicate that none of the evaluated categorical clinical characteristics demonstrated a statistically significant association with classical versus atypical PR in this cohort.

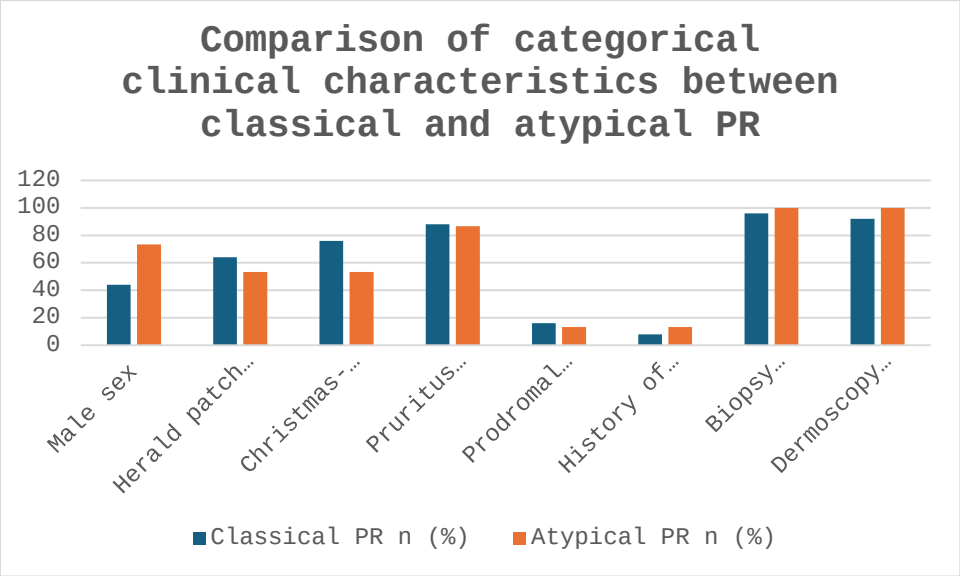


Table 8. Age-group distribution according to clinical variant

Age group	Classical PR (n)	Atypical PR (n)	Total
<12 years	2	3	5
12–17 years	2	0	2
18–29 years	15	7	22
30–44 years	6	5	11

The 18–29-year age group represented the largest proportion of both classical and atypical PR cases, accounting for 15 classical and 7 atypical cases. Among children below 12 years, 3 cases were atypical and 2 were classical. Both patients aged 12–17 years had classical PR. In the 30–44-year age group, 6 patients had classical and 5 had atypical PR. Overall, the distribution demonstrated that young adults represented the largest subgroup for both clinical presentations.

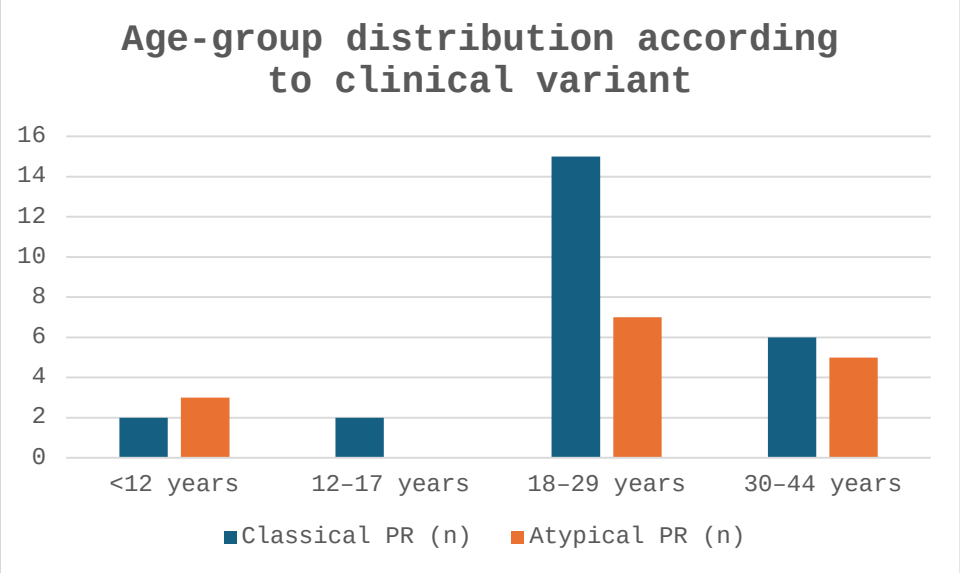
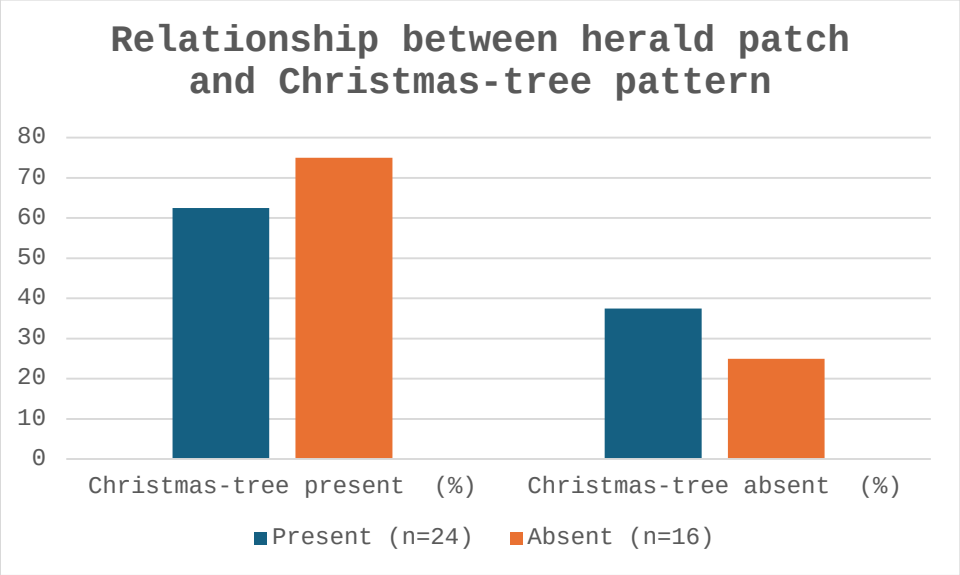
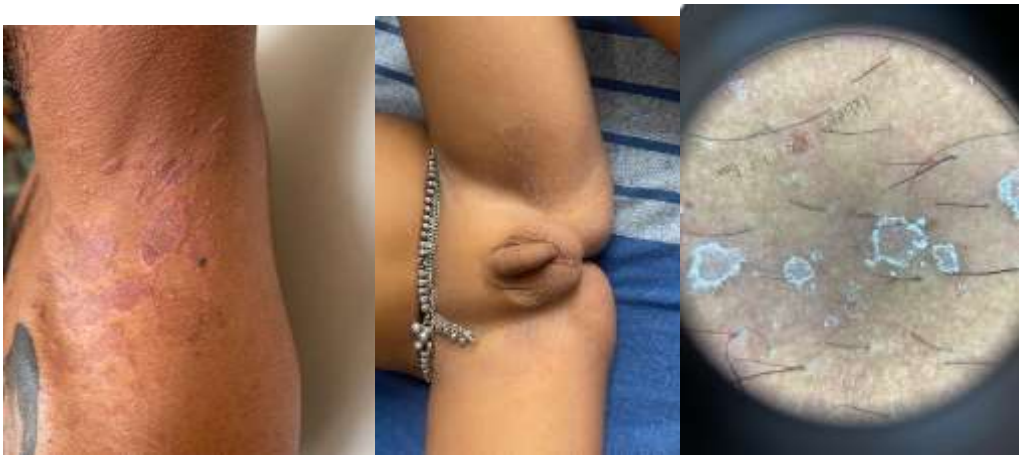


Table 9. Relationship between herald patch and Christmas-tree pattern (n = 40)

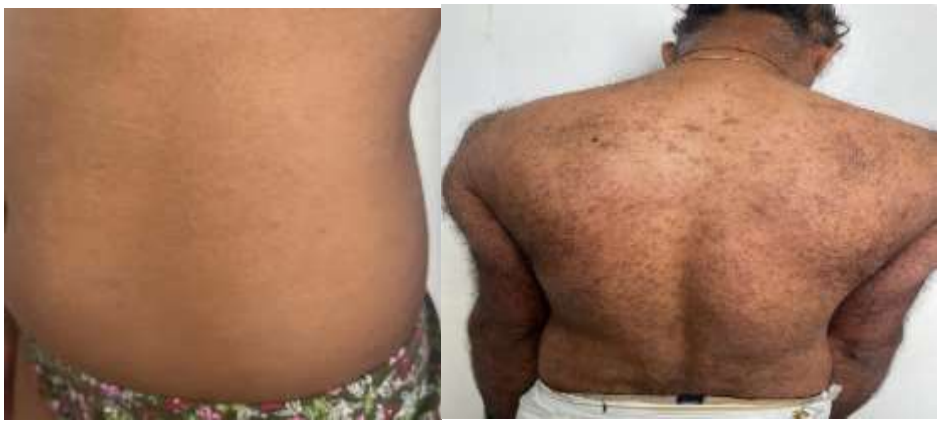
Herald patch	Christmas-tree present n (%)	Christmas-tree absent n (%)
Present (n=24)	15 (62.5)	9 (37.5)
Absent (n=16)	12 (75.0)	4 (25.0)
Fisher's exact test		**p = 0.503**

Among patients with a herald patch, the Christmas-tree distribution pattern was present in 62.5%, while among patients without a herald patch, the pattern was present in 75.0%. Despite this apparent difference, the association was not statistically significant (Fisher's exact p = 0.503). Therefore, the presence of a herald patch was not significantly associated with the presence of the Christmas-tree distribution pattern in this study population.





HERALD PATCH INVERSE PR Dermoscopy of PR



Papular PR Classic PR with Christmas tree pattern

4. Discussion

Pityriasis rosea (PR) is an acute papulosquamous disorder with classical and atypical presentations. In the present study of 40 patients, classical PR accounted for 62.5%, while atypical PR constituted 37.5%. Papular and inverse PR were the commonest atypical variants, each comprising 40.0% of atypical cases. The mean age was 23.6 ± 10.1 years, with 55.0% belonging to the 18–29-year age group and 55.0% being male. The younger age distribution was comparable with Özyürek et al., who reported a mean age of 29.3 ± 9.5 years among 52 adults, and Shende et al., who reported a mean age of 30.8 ± 15.7 years among 50 patients [11,12]. Thus, PR predominantly affected younger individuals in both the present and previous studies.

Pruritus with red lesions was the most frequent clinical feature in the present study, occurring in 87.5% of patients. A herald patch was present in 60.0%, while the Christmas-tree pattern was observed in 67.5%. Prodromal symptoms and preceding drug intake were reported in 15.0% and 10.0%, respectively. Özyürek et al. reported recent respiratory infection in 51.9%, gastrointestinal infection in 28.8%, and new clothing exposure in 75% of patients [11]. The lower frequency of prodromal symptoms in the present study may reflect differences in study populations and clinical assessment. Importantly, the absence of a herald patch in 40.0% of the present patients indicates that this classical feature was not consistently present and should not be considered essential for diagnosis. Atypical PR constituted 37.5% of cases in the present study, closely resembling the 40% atypical presentation reported by Shende et al. in their 50-patient study [12]. This similarity emphasizes that atypical PR represents an important proportion of cases in clinical practice. Shende et al. specifically highlighted the role of biopsy in distinguishing atypical PR from clinical mimickers [12]. In the present study, papular and inverse PR were the predominant atypical variants, followed by EMF-like and excoriated papular forms. These findings reinforce the need for careful morphological assessment when lesions do not follow the classical pattern.

No statistically significant differences were observed between classical and atypical PR regarding age, disease duration, sex, herald patch, Christmas-tree pattern, pruritus, prodromal symptoms, drug history, biopsy, or dermoscopy. The mean age was 23.4 ± 8.4 years in classical PR and 24.1 ± 12.8 years in atypical PR ($p = 0.834$). Median disease duration was 5.0 days in both groups ($p = 0.672$). Although males were more frequent in the atypical group than the classical group (73.3% vs. 44.0%), this difference was not statistically significant ($p = 0.104$). These findings suggest that demographic and routine clinical characteristics alone may not reliably distinguish classical from atypical PR, supporting the importance of detailed clinical and histopathological evaluation.

Histopathologically, the present study demonstrated overlapping inflammatory patterns across PR variants. Classical PR showed spongiosis, parakeratosis, superficial perivascular lymphocytic infiltration, lymphocytic exocytosis, and erythrocyte extravasation. Papular PR showed spongiotic and perivascular lymphocytic changes with mild acanthosis, while inverse PR demonstrated subacute spongiotic dermatitis with perivascular lymphocytic infiltration and erythrocyte extravasation. These findings were comparable with Shende et al., who reported spongiosis in 44%, parakeratosis in 38%, irregular acanthosis in 34%, perivascular lymphocytic infiltrate in 56%, and RBC extravasation in 36% of 50 patients [12]. The similarity in major histopathological features supports their value in recognizing PR, particularly in atypical presentations.

The inflammatory histopathological pattern was also consistent with Neoh et al., who examined 12 biopsy specimens from six patients and reported parakeratosis, orthokeratosis, epidermal hyperplasia, and spongiosis. Their immunohistochemical examination demonstrated predominant CD3-positive T-cell infiltration with an increased CD4+/CD8+ ratio, with no significant histopathological differences between herald and secondary lesions [13]. The superficial perivascular lymphocytic infiltration and lymphocytic exocytosis observed in the present study were compatible with these inflammatory findings. However, immunohistochemical assessment was not performed in the present study, so direct comparison of T-cell subsets was not possible. Similarly, Özyürek et al. reported eczematous histopathological changes with CD3-positive and CD20-negative inflammatory infiltrates in 52 adult patients, supporting a predominantly cell-mediated inflammatory response in PR [11]. The present study also demonstrated prominent spongiotic and lymphocytic changes, supporting the inflammatory histomorphological nature of PR. However, unlike their study, the present investigation did not perform immunohistochemistry; therefore, the findings should be considered histopathological rather than immunophenotypic evidence.

The diagnostic importance of histopathology in atypical PR was further supported by Shende et al., who emphasized biopsy for differentiation from mimicking disorders [12]. Ibraheim et al. [14] further evaluated IL-36 immunostaining in 21 PR, 22 pityriasis lichenoides, and 10 psoriasis cases. All psoriasis cases were IL-36 positive, whereas all PR cases were negative, with a highly significant difference ($p = 0.00000002$) [14]. Although IL-36 staining was not performed in the present study, these findings indicate that immunohistochemical markers may provide additional diagnostic value when routine clinical and histopathological findings are inconclusive. The herald patch also demonstrated considerable variability. In the present study, it was present in 60.0% of patients, and no significant association was found between the herald patch and Christmas-tree pattern ($p = 0.503$). Drago et al. compared 19 patients with an isolated herald patch with 19 age- and sex-matched classical PR controls and reported shorter disease duration and lower HHV-6/HHV-7 viral DNA loads in the isolated-herald-patch group [15]. They suggested that isolated herald patch presentation may represent an abortive form of PR related to a stronger host immune response [15]. The present study did not assess viral DNA or specifically evaluate isolated herald-patch cases; therefore, the findings are not directly comparable, but they further illustrate the clinical variability of PR. The present study demonstrated substantial clinical and histopathological variability in PR, with atypical forms comprising an important proportion of cases. The absence of significant differences between classical and atypical PR on routine clinical parameters highlights the importance of clinicohistological correlation, particularly when the presentation is unusual or overlaps with other papulosquamous disorders.

Conclusion

Pityriasis rosea demonstrated a broad spectrum of clinical presentations, ranging from classical disease to several atypical variants. Although the characteristic clinical features were commonly observed, they were not consistently present in all patients, highlighting the variability of presentation. Atypical forms, particularly papular and inverse variants, may pose diagnostic challenges because of their resemblance to other papulosquamous disorders. Histopathological examination demonstrated characteristic inflammatory and epidermal changes that supported the clinical diagnosis and provided useful diagnostic information in atypical cases. The study emphasizes that careful clinical examination combined with appropriate histopathological evaluation is important for accurate diagnosis and recognition of atypical pityriasis rosea. Clinicohistological correlation can therefore help differentiate PR from its important clinical mimickers and improve diagnostic confidence in cases with unusual morphology or distribution.

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