

Epidemic Observation Unit

PITYRIASIS ROSEA

Medical Research Council Enquiry

Nothing is known of the cause of this comparatively rare, but apparently quite harmless, condition, which is not often seen in hospital. It usually affects children or young adults, it runs its course in six to eight weeks, its distribution is that of a high-necked, short-sleeved vest, and the herald patch and the centripetal scaling of the medallions make its clinical recognition easy in the majority of patients. It is suggested that, if general practitioners would observe and record each case, as it occurs, in their own words and with their own comment, some clue to the aetiology might appear.

What is required, therefore, is not a clinical description, but a note of any accompanying feature in the environment, which might possibly have something to do with pityriasis rosea, e.g., occupation, food, clothing, seasonal incidence, concurrent allergy, infectious fever, and the like, either in the patient or in others.

The services of the epidemic observation unit have been offered to the M.R.C.'s Committee for Research in General Practice.

Every doctor diagnosing a case of this condition during 1959 is invited to notify the director of the Unit (see notification form No. 5 at the end of the Journal).

A short questionnaire will then be sent, on which more information can be provided. The notification of doubtful cases is not required, but for convenience an extract from Sequeira's *Diseases of the Skin*, 6th Edition, 1957, pp. 208-210, is given below.

"Clinical features. There are two kinds of lesion: (1) small rounded rose-coloured spots covered with a fine scale and (2) medallions of oval form, pink in colour, scaly at the margins, and with a central yellowish area upon which there are marks resembling a water-mark, due to fine ridges on the epidermis. The marginal collarette of scale is attached peripherally and hangs freely towards the centre of the lesion. Some of the smaller lesions may have urticarial characters. The spots rarely exceed $\frac{1}{2}$ to $\frac{3}{4}$ inch in diameter.

"The two forms of the eruption are in varying proportion in different cases. The disease affects the trunk and the proximal parts of the limbs first—in fact, the area covered by the vest or bathing suit—but it may extend to the forearms.

"The evolution of the disease is highly characteristic. There is an initial lesion or 'herald spot', usually somewhere on the trunk, or on the neck or a limb. This patch is red and scaly, and may be mistaken for tinea circinata. The herald spot may itch slightly, but is often overlooked by the patient, especially if on the back. The herald spot is observed in rather more than 50 per cent of cases. It is often obvious from its size and character when the generalized eruption has developed. The erupt-

ion of spots occurs from a few days to two or three weeks after the appearance of the primary or herald. The outbreak consists of rounded spots and medallions, first on the trunk following the lines of the ribs and then on the adjacent parts of the limbs. They may come out in successive crops, but the eruption is self-limited, and after lasting from about four to six weeks the spots fade, the scales fall off, the skin resumes its normal appearance without scar or stain. Itching is a very variable symptom but is usual in adults and rare in children. At times it is severe and may persist with the general eruption for two or three weeks. It is exceedingly rare to meet with a second attack in the same subject.

“ Slight pyrexia has been observed and also glandular swelling at the onset.

“ The *diagnosis* is important, and mistakes are not uncommon. Eczema is excluded by the oval medallion-like plaques and the primary patch and distribution of the eruption. Seborrhoeic dermatitis affects often the same regions, but the scalp is usually scaly, and the trunk lesions are covered with greasy squames and tend to coalesce. In the absence of a herald spot it may be difficult to be certain of the diagnosis until the course of the eruption has been noted. Seborrhoeic pityriasis clears readily under treatment.

“ In psoriasis the spots are a characteristic and deeper colour and well demarcated; there is a silvery scaling, and fine bleeding points are found when the scales are removed by scraping. Erythema multiforme is distinguished by the purplish tint of the eruption, its predilection for the distal parts of the extremities, and the absence of scaling, and of the medallions and the presence of target lesions ”.

FARMER'S LUNG INVESTIGATION

Information about this enquiry has been already published in the College Journal, No. 20 (1958), vol. 1, p. 309 and in the Annual Report 1958, p. 43; and some doctors have already used Notification Form No. 4 to notify cases or nil returns. It has been suggested that further information, both about the condition and about the scope and methods proposed for the survey, would be helpful.

The purpose of the enquiry

Our aim is to carry out a retrospective and prospective epidemiological enquiry into the regional and seasonal distribution of a clinical syndrome, and to prepare the way for an intensive investigation of a few selected patients by specialists interested in problems related to its aetiology.

Method

The survey is planned in three phases—a widely distributed questionnaire to ascertain numbers of cases, and both a retrospective

and a prospective enquiry to discover clinical facts.

Phase 1. A large number of members and associates, selected by reason of the geographical situation of their practices, or of their own known or stated interest in respiratory diseases, will receive the questionnaire, together with explanatory notes, clinical descriptive notes, and the criteria for diagnosis (see below). A high percentage of returns is hoped for and, as no published report upon this complaint in this or any other country has as yet produced evidence about the geographical distribution of cases, NIL returns are of very great importance.

From the returned questionnaires, it will be possible to identify (1) a number of doctors who have had cases under their care in the past; (2) the number of past cases in relation to an estimate of population; (3) a number of doctors who will be willing to join a "prospective" study lasting perhaps two years.

Phase 2. (The retrospective study). Those doctors who have cared for cases in the past will be asked to complete a record sheet, and from these records a sufficient amount of information may be collected to show broad outlines of the disease.

Phase 3. (The prospective study). Those doctors who volunteer, or who notify *new* cases from now onwards, will receive detailed instructions as to the aims, methods, and documentation required during this phase. It is here that the greatest amount of work and the most useful information will be found. These results may show in considerable detail the picture displayed by a small number of cases.

It is also expected that a very few cases, discovered in this phase, may be suitable for intensive study by a team of specialists. The procedure for notifying such cases will only be given to the participating doctors individually concerned.

The Clinical Syndrome

The known basic facts about "Farmer's Lung" are that:

(1) The patient becomes ill, with a respiratory illness, as a result of breathing fungus-contaminated vegetable dust, either on a particular occasion or over a period of time.

(2) The illness, either by symptoms, signs, or course is not quite straightforward.

(3) To a reader familiar with this complaint, the x rays appearances are characteristic.

Beyond this, the disease is not fully documented, and considerable variation is reported in the speed of onset, symptoms, signs, and severity. The disease seems to range from a few days cough and

“tightness,” through a short acute pneumonia-like illness, to an incapacitating illness of slow onset and many months duration. Occasionally a number of people will be exposed together to the same dust conditions, e.g., a threshing-team, and several cases may occur concurrently. These “multiple-case outbreaks”, though rare, are likely to be of the utmost importance to this survey, *Any doctor encountering such multiple cases is asked to telephone or write at once to the director of the Epidemic Observation Unit.*

The percentage of cases falling into each of these categories is unknown. The discovery of this information and of other facts about the clinical syndrome, as presented by the patient to his doctor, is among the objects of this survey. All participants in the prospective enquiry will receive guidance in greater detail about the clinical aspect of the survey.

Please refer to the Notification Form at the end of this Journal.

The Criteria for Diagnosis

- POSITIVE
1. A history of recent or continuing exposure to *vegetable dust*,* which is believed to be fungus contaminated, shortly before the onset of symptoms.
 2. Dyspnoea, defined as “shortness of breath,” and/or cough, coming on after the above exposure.
 3. The presence of abnormal physical signs in the chest.

*To date the dusts of hay, straw, corn, other grains, ground grain products, peat substitutes, beans, and peas have all been suspected.

- NEGATIVE
4. The absence of findings pathognomonic of other pulmonary diseases, particularly pulmonary tuberculosis, mineral pneumoconiosis, and neoplasm.
 5. The absence of a clinical course characteristic of “conventional” acute bacterial infection.

All the above criteria are obligatory before a case can be included in the enquiry.

- IF POSSIBLE
6. Characteristic radiological findings. Do not let the absence of x-ray report, or a doubtful x ray report, stop you submitting the case for this survey, together with any x-ray films available.

CONGENITAL ABNORMALITIES

I.

Incidence among children under 5 years

A joint enquiry is being made by the unit and Dr J. C. MacDonald, epidemiologist of the Public Health Laboratory Service, into the occurrence of major congenital abnormalities. The aim is partly to record the present seasonal and regional incidence of such abnormalities, and partly to search for aetiological clues.

Every doctor who attends or knows of a child of 5 years of age or less, affected by a major congenital abnormality, is asked to notify the director of the unit on the notification form at the end of this journal. He will later be asked to record the clinical details on a form, on which there is also space to give any opinion or conjecture about the cause of the affection.

II.

Febrile Illness in Pregnancy

In a recent report about maternal factors associated with the appearance of congenital abnormalities in infants, Dr Alison D. MacDonald (1958) focussed attention particularly on the occurrence of febrile illness during pregnancy.

Dr B. C. S. Slater has offered to act as recorder in a prospective enquiry by the unit into various maternal factors, which might adversely affect the foetus during pregnancy. The first factor to be thus examined will be the occurrence of a febrile illness during a current pregnancy. Every doctor who attends a patient with such an illness, or who hears about it at a routine antenatal examination, is asked to notify the director of the unit on the notification form at the back of each number of the journal. He will then be asked to fill up a report about the pregnancy and the illness and, later, will be asked to report also about the condition and development of the baby.

REFERENCE

McDonald, A. D. (1958), *New England J. Med.*, **258**, 767.
