DermaCase

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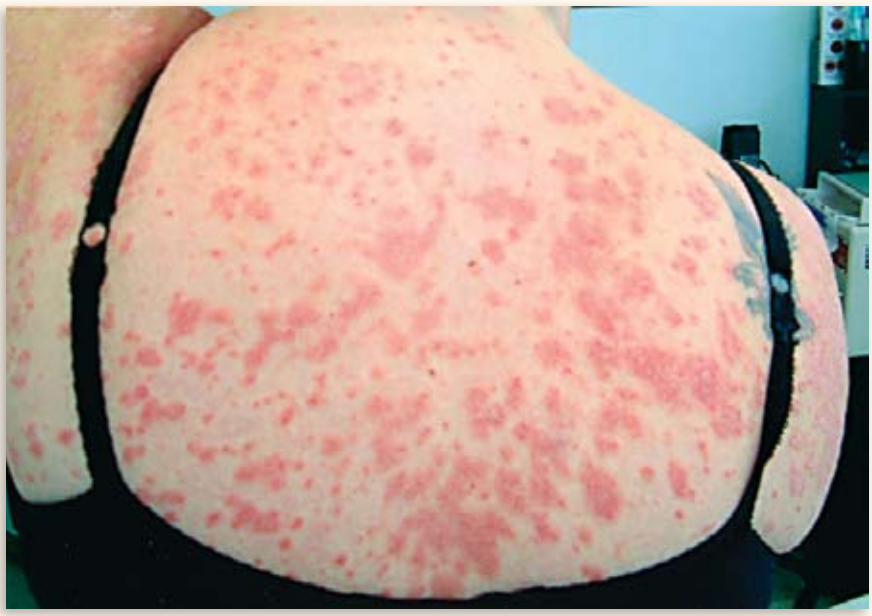

CAN YOU IDENTIFY THIS CONDITION?

A healthy 38-year-old woman presented with a scaly, indurated, erythematous rash on her chest, back, and arms. She had been treated with 1% hydrocortisone ointment, but had not improved. She was currently using estradiol and levonorgestrel (Alesse) for birth control.

The most likely diagnosis is:

1. Pityriasis rosea
2. Cutaneous lupus erythematosus
3. Chronic form of nummular dermatitis
4. Psoriasis

Answer on page 1080

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4. Psoriasis

Psoriasis is a common debilitating autoimmune skin condition characterized by red sharply demarcated papules and plaques with a silvery-white scale. It affects up to 2% of the population and is thought to be inherited in a polygenic fashion. About 35% of patients with psoriasis have a family history of the disease.[1]

Several environmental factors can trigger psoriasis in susceptible people: infection, most commonly streptococcal infection; trauma to the skin (Köbner phenomenon); drugs (ie, glucocorticoids, antimalarials, lithium, beta-blockers, and systemic interferon and terbinafine); and stress. It appears to affect men and women equally. Age of onset follows a bimodal distribution; psoriasis peaks between age 20 and 30 and between age 50 and 60.[1]

The clinical presentation of psoriasis varies depending on its morphologic subclass. Plaque psoriasis is the most common. It is usually concentrated on the extensor surfaces (ie, elbows, knees, and lumbar back) and on the scalp, postauricular and genital areas, palms, soles, joints, and nails.[1]

Onset is usually gradual with papules that progress to well circumscribed and sharply demarcated light pink, brown, red, or maroon plaques covered with a silvery-white scale. If pulled, the scale comes off in layers, causing sites of punctate bleeding (Auspitz sign). Plaques and scaling are usually thicker on the scalp, trunk, and extensor surfaces and thinner in body folds.[1]

Diagnosis

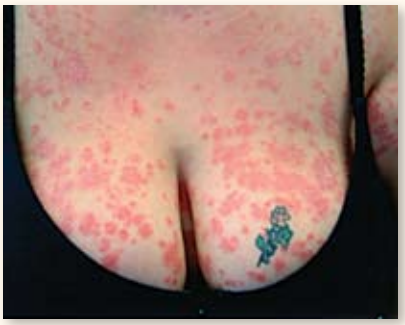
Diagnosis of psoriasis is mainly made on clinical grounds. History and physical examination are usually diagnostic and should include a screen for arthritis because up to 30% of patients with psoriasis have joint involvement (psoriatic arthritis).[1] Skin biopsy can be helpful in difficult cases.

The differential diagnosis includes pityriasis rosea, seborrheic dermatitis, lichen simplex chronicus, psoriasiform drug eruptions, mycosis fungoides, and pustular eruptions.[1]

Psoriasis can be classified according to the total body surface area involved. Mild psoriasis involves <2% of the surface area, moderate psoriasis covers 2% to 10% of the surface area, and severe psoriasis covers >10% of the surface area.

Management

Management of psoriasis is often a clinical challenge and depends on where it occurs and how much of the total body surface area is involved. Various treatments have been used for topical and systemic therapy. Corticosteroids still remain the mainstay of topical treatment for psoriasis, but their side effects limit their use.[2]



Hydrocortisone 1% cream, topical immunomodulators (eg, tacrolimus or pimecrolimus cream), and topical vitamin D analogues (eg, calcipotriol cream) are useful for plaque psoriasis on the face and in body folds.[2] They can be applied twice daily for up to 8 weeks. If no improvement is noted, patients should be referred to a dermatologist.

Scalp psoriasis can be managed with topical preparations of tar and salicylic acid, such as Sebcur-T (10% tar with 4% salicylic acid) and Neutrogena T/gel (0.5% tar) medicated shampoos once daily, Diprosalic lotion (0.05% betamethasone and 2% salicylic acid) twice daily, and amcinonide ointment once daily. The retinoic acid derivative Tazorac (0.05% to 0.1% tazarotene cream), applied nightly, is also effective treatment for scalp psoriasis, but must be used in combination with steroids to prevent irritation.[2]

Sequential therapy with topical vitamin D analogue ointment mixed with halobetasol 0.05% ointment first for 2 weeks followed by halobetasol ointment twice weekly (Monday and Thursday) as maintenance therapy can be used for patients with mild body psoriasis. This combination should not be used on the face or in body folds.[2]

For more extensive psoriasis, psoralen plus ultraviolet-A topical therapy administered 2 to 3 times a week for 10 weeks is effective in approximately 90% of patients. Recently, narrow-band (311 nm) ultraviolet-B therapy has proven more effective than broadband ultraviolet-B therapy. It is safer but less effective than psoralen plus ultraviolet-A treatments.[2]

Several systemic agents have been used as therapy for psoriasis. Methotrexate, cyclosporin, and acitretin are most widely used. Rotating ultraviolet light and systemic medications can help prevent toxicity from continuous use of any one therapy.[3]

Several biologic therapies for psoriasis are currently under investigation. They include infliximab, etanercept, efalizumab, and alefacept. Biologic therapies, though costly, might offer a less toxic alternative to traditional systemic therapies.[3]

References

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