Dermoscopy May be a Valuable Additional Tool in Diagnosis of Pityriasis Rubra Pilaris: Letter to the Editor

Dermoskopi, Pitriyazis Rubra Pilaris Tanısında Değerli Bir Ek Tanı Aracı Olabilir

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Eighteen-year-old female patient with with red scaly plaques on her forearms, legs and scalp, was referred to our out-patient clinic (Figure 1). The disease duration was over 10 years. The female patient was previously diagnosed as psoriasis. She was treated with various topical anti-psoriatic agents unsuccessfully. The lesions were not completely cleared. The patient was evaluated and clinical differential diagnosis included a number of erythematosquamous skin diseases. Due to the shape and arrangement of lesions , the diagnosis of seborrheic dermatitis, pityriasis rosea, lichen planus, pityriasis lichenoides et varioliformis acuta, pityriasis lichenoides chronica and parapsoriasis were excluded. And preliminary diagnosis of pityriasis rubra pilaris (PRP) and psoriasis were concluded. Skin punch biopsy was performed from her left forearm. Histopathological examination showed parakeratosis, loss of granular layer limited to small foci with diffuse hypergranulosis, and perivascular lymphocyte, histiocytes and extravasated erythrocytes in upper dermis (Haematoxylin-Eosin, original magnification x100) (Figure 2). These histopathological features were not fully consistent with psoriasis and did not exclude the diagnosis of PRP. Later, we performed dermoscopic examination on erythematous plaques and it revealed round/oval yellowish areas surrounded by vessels of mixed linear and dotted morphology (Figure 3). These findings were consistent with dermo-

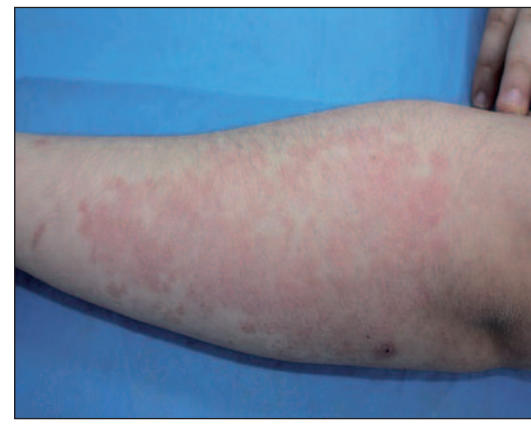

FIGURE 1: Red scaly plaque on her left forearm.
(See color figure at http://www.turkiyeklinikleri.com/journal/dermatoloji-dergisi/1300-0330/)

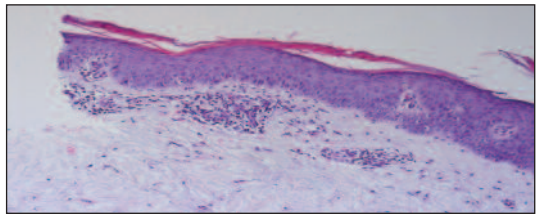

FIGURE 2: Parakeratosis, loss of granular layer is limited to small foci with diffuse hypergranulosis, in upper dermis perivascular lymphocyte, histiocytes and extravasated erythrocytes (HE, original magnification x100).
(See color figure at http://www.turkiyeklinikleri.com/journal/dermatoloji-dergisi/1300-0330/)

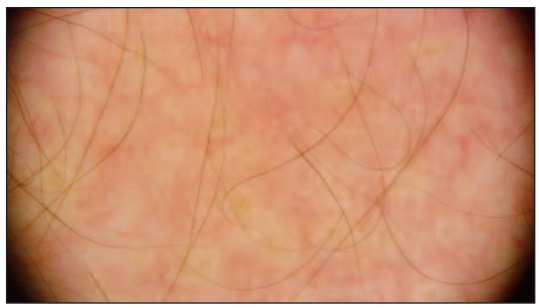

FIGURE 3: Dermoscopic findings revealed round/oval yellowish areas surrounded by vessels of mixed linear and dotted morphology.
(See color figure at http://www.turkiyeklinikleri.com/journal/dermatoloji-dergisi/1300-0330/)

scopic features of PRP. And the patient was diagnosed as PRP type 4. Papulo-squamous skin diseases are variable, however they are very close in their clinical features. Clinical evaluation of skin lesions is based on common sense and experience of the dermatologist to differentiate features of each disease.[1] However, unusual presentations at times do exist and may cause difficulties in the differentiation among these entities. In those cases, histopathology contributes significantly to the accurate diagnosis.[2] However, in rare instances, histopathology may be insufficient in the diagnosis of papulo-squamous diseases. The dermoscope is a low-cost, noninvasive device that is readily available in daily clinical practice. Although the diagnosis of psoriasis is usually straightforward, at times it may be challenging to differentiate it from PRP. Recently, dermoscopy has been reported to be helpful in the distinction between these 2 entities. In the literature, it was stated that dermoscopic pattern of psoriasis consisted of uniformly distributed, dotted vessels on a light red background and red globules, twisted hairpin and glomerular vessels could also be seen under dermoscopy.[3,4] However, the dermoscopic pattern of PRP consisted of round/oval yellowish areas surrounded by vessels of mixed morphology.[5] The dermoscopic findings of erythematous plaques of the patient presented herein is consisted with the PRP findings of the latter study. As a result of clinical and dermoscopic features, the patient was diagnosed as PRP type 4 and 25 mg oral dose of acitretin was administered for the treatment.

In conclusion, still retaining the clinicopathological correlation as the 'gold standard' in doubtful cases, dermatoscopy may be used to differentiate PRP from psoriasis. And additionally, dermoscopy might permit the differential diagnosis between both entities and avoid unnecessary biopsies in some cases. However, further larger studies are required to confirm the diagnostic value of dermoscopy in terms of differentiating PRP from psoriasis.

REFERENCES

1. Mashaly HM, Masood A, Mohamed A. Classification of papulo-squamous skin diseases using image analysis. Skin Res Technol 2012;18(1):36-44.
2. Lallas A, Kyrgidis A, Tzellos TG, Apalla Z, Karakyriou A, Karatolias A, et al. Accuracy of dermoscopic criteria for the diagnosis of psoriasis, dermatitis, lichen planus and pityriasis rosea. Br J Dermatol 2012;166(6):1198-205.
3. Lallas A, Apalla Z, Karteridou A, Lefaki I. Dermoscopy for discriminating between and psoriasis. J Dermatol Case Rep 2013;7(1):20-2.
4. Kim G, Jung HJ, Ko HC, Kim MB, Lee WJ, Lee SJ, et al. Dermoscopy can be useful in differentiating scalp psoriasis from seborrhoeic dermatitis. Br J Dermatol 2011; 164(3):652-6.
5. Lallas A, Apalla Z, Tzellos T, Lefaki I. Photoletter to the editor: dermoscopy in clinically atypical psoriasis. J Dermatol Case Rep 2012;6(2):61-2.