

Pityriasis Alba in a Psoriatic Location

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Three patients with pityriasis alba whose lesions were confined to the knees only are reported. Such cases can be misdiagnosed as psoriasis. The key to the correct diagnosis lies in the physician's awareness of the existence of this variant of pityriasis alba. Key words: Knees; Psoriasis.

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Pityriasis alba is a relatively common skin disorder, usually seen in pre-adolescent children. In this age group the incidence may reach 30–40% (1). The individual lesion is a round or oval patch, 0.5 to 5 cm in diameter, with fine, loosely adherent scales. The margins are moderately sharp and may be slightly elevated. There may be an initial stage in which the lesions have an erythematous appearance, but patients usually seek doctor's advice when the lesions become hypopigmented. Lesions are limited to the face in 50–60% of the cases. In a further 20%, the neck, arms and shoulders are also involved. Adamson (2) described an uncommon clinical variant in which the lesions are distributed symmetrically over the buttocks, upper thighs, lower back and extensor aspects of the arms. Widespread involvement occurs more frequently in older children and young adults. This condition has been referred to as "extensive pityriasis alba" (3). This uncommon variant of pityriasis alba has been further categorized into the idiopathic form and the atopic form (4).

We here described 3 patients with pityriasis alba whose lesions were located only on the knees. This variant of pityriasis alba is probably the same as R. L. Sutton Jr. described some years ago (5), called "summertime pityriasis of the elbows and knees".

CASE REPORTS

Case 1

A 10-year-old boy presented with a 6-month-history of hypopigmented scaly plaques on his knees. He had been diagnosed as suffering from psoriasis and had been treated unsuccessfully with steroid ointments. On physical examination two symmetrical oval plaques were seen on his knees, each 4×5 cm in diameter. They were hypopigmented and appeared lighter than the surrounding skin. Fine adherent silvery scales covered the plaques. Since the patient was asymptomatic, he was told to use only emollient creams after bathing. No change has been noted over 6 months' follow-up.

Case 2

A 9-year-old boy presented with a history of white scaly plaques of 2 months' duration, on his knees. As in the previous case two sharply demarcated, hypopigmented, scaly plaques were seen on both knees. The plaques resolved spontaneously 4 months after their appearance.

Case 3

A 19-year-old male presented with a large, scaly plaque on his right knee and a smaller and flatter plaque on his left knee. He had been treated for several months, with steroid ointments, by a dermatologist who had diagnosed psoriasis. A large, scaly plaque, lighter than the surrounding skin, was seen on his right knee. It was sharply demarcated, and the edges were erythematous and slightly elevated. A smaller lesion seen on his left knee was actually a white macule with smooth surface. The patient was told to stop any treatment. No change has been noted over 1 month follow-up. A punch biopsy of the lesion showed mild hyperkeratosis, parakeratosis of the epidermis and slight edema of the upper dermis, with a mild chronic inflammatory infiltrate.

DISCUSSION

Psoriasis must be considered as a differential diagnosis when pityriasis alba is located on the knees. The plaques of pityriasis alba are, however, flatter and smoother, and they are of a softer consistency than the psoriatic plaques. In addition, in the psoriatic plaques the Auspitz sign can be elicited, while in pityriasis alba plaques the sign does not appear. The fact that we saw two cases (1 and 2) in the same week, and the third case one half year later, supports our belief that we are not dealing with a rare disease.

We suggest the name "Psoriasis-like pityriasis alba" for this variant of the disease or according to Sutton "pityriasis alba of the elbows and knees".

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