PARTICULAR TYPES OF PSORIASIS

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Summary

Psoriasis is a chronic multisystemic disease that can take on different clinical morphologies and can present both in classic locations and in less frequently affected areas. With this paper we aim to describe the forms of psoriasis with particular locations: palpebral, of the ear lobe, of the tip of the nasal pyramid, psoriasis gyrata, Blaschko-linear psoriasis, as well as psoriasis with particular involvement: Hallopeau acrodermatitis, reactive arthritis and psoriatic onycho-pachydermo-periostitis of the hallux.

Key words: *psoriasis, palpebral, ear lobe, nasal piramid, gyrata, Blaschko-linear, Hallopeau acrodermatitis, reactive arthritis, onycho-pachydermo periostitis of the hallux.*

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Particular types of psoriasis

Psoriasis is a chronic multisystemic disease that can affect the skin, mucous membranes and nails, as well as the joints and internal organs. Psoriasis lesions can take on different clinical morphologies and can appear both in classic locations and in less frequently affected areas.

Psoriasis with particular locations

Palpebral psoriasis

Palpebral involvement in psoriasis, similar to psoriatic cheilitis, is uncommon, presenting as slightly scaly erythematous plaques. This type of psoriasis is not accompanied by dry eye. The volume of the Meibomian gland secretions remains the same, but they are much more viscous, which can lead to obstruction and inflammation. There is also an increased epithelial turnover in the conjunctiva and in the Meibomian glands [1].

Psoriasis is part of the differential diagnosis of scaly blepharitis, especially with seborrheic dermatitis. A study carried out on 447 patients with blepharitis revealed that the causes were irritant dermatitis in 21% of the cases, atopic dermatitis in 13.5% and psoriasis in only 2.3%. In another study of 105 patients with blepharitis, psoriasis was identified in only 3.8% of patients [2].

Psoriasis of the ear lobe and tip of the nasal pyramid

The presence of erythemato-squamous plaques on the ear lobe associated with scaly lesions on the scalp directs the diagnosis towards psoriasis. Nasal pyramid involvement occurs in the context of facial psoriasis.

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Psoriasis gyrata

Psoriasis gyrata represents a particular form described in the works of the 19th century. Clinically, it presents as large lesions in the form of arabesque, especially on the trunk. Sometimes, in the early stages, the lesions can take an annular form, which in time can lead to extended polycyclic forms.

Blaschko-linear psoriasis

Like in other inflammatory diseases, psoriasis can sometimes take on a Blaschko-linear appearance, which is due to mosaicism. These forms of psoriasis should not be confused with inflammatory linear epidermal nevus (ILVEN), Blaschko-linear lichen or lichen striatus, biopsy remaining sometimes necessary to establish the diagnosis.

It should be noted that in the case of generalized psoriasis there may be „psoriasis-free" lines. Also, there are situations when, in patients with generalized psoriasis treated with biological medication, the majority of the lesions regress, while several Blaschko-linear psoriasis lesions persist [3].

Psoriasis with particular involvement

Hallopeau acrodermatitis

Hallopeau acrodermatitis is a very rare form of pustular psoriasis. It can begin during childhood, clinically being characterized by erythema covered with pustules and scales associated with nail involvement and also with involvement of the distal extremity of the fingers and toes. The hands are more frequently affected and the lesions are usually asymmetrical. In evolution, the disease can remain localized for years, or it can extend towards the proximal extremity of the fingers and palms. Progressive resorption of the distal phalanx is also possible, destroying the nail apparatus, finally giving the appearance of a „thinned finger". Sometimes Hallopeau acrodermatitis can be associated with generalized pustular psoriasis and geographic tongue.

Reactive arthritis

Reactive arthritis, also known as Fiessinger-Leroy-Reiter syndrome or Reiter syndrome, is defined by the historical triad: urethritis, acute or subacute asymmetric polyarthritis and conjunctivitis, the complete form of the syndrome being present in a third of patients. Reactive arthritis is usually triggered by either a urethral or digestive tract infection, the main culprits being infectious agents such as Chlamydia trachomatis, Mycoplasma, Ureaplasma, Salmonella, Shigella, etc.

Cutaneous-mucosal manifestations occur in 20% of reactive arthritis cases, especially in post-venereal forms. These include elusive oral lesions, circinate balanitis with round, polycyclic, scaly and sometimes erosive psoriasiform lesions, palmo-plantar keratoderma (keratoderma blennorrhagicum) with „en clous de tapissier" (tapestry nail) lesions, psoriasiform plaques of the limbs having a very thick stratum corneum resembling a rough squamo-crust and subungual hyperkeratosis. The histopathological examination of skin lesions regardless of their location, is typical for psoriasis, and in the case of oral erosions, it resembles pustular psoriasis.

The differential diagnosis of reactive arthritis should include arthropathic psoriasis as noted by Belz et al. [4], with which it has a number of common features. These include radiological, cutaneous and histological aspects, nail abnormalities, sausage finger, oligoarthropathy, sacroiliitis, talalgia. Both conditions have seronegative rheumatoid factor and antinuclear antibodies and an increased incidence of HLA-B27 positivity.

Psoriatic onycho-pachydermo periostitis of the hallux

Psoriatic onycho-pachydermo-periostitis of the hallux (OP3GO) is not specific to the hallux, as it can also affect other fingers and toes. It can occur either isolated or associated with psoriasis lesions. OP3GO is characterized by the association, in the same finger, of psoriatic onychopathy with distal soft tissue enlargement and

Figure 1. Palpebral psoriasis.

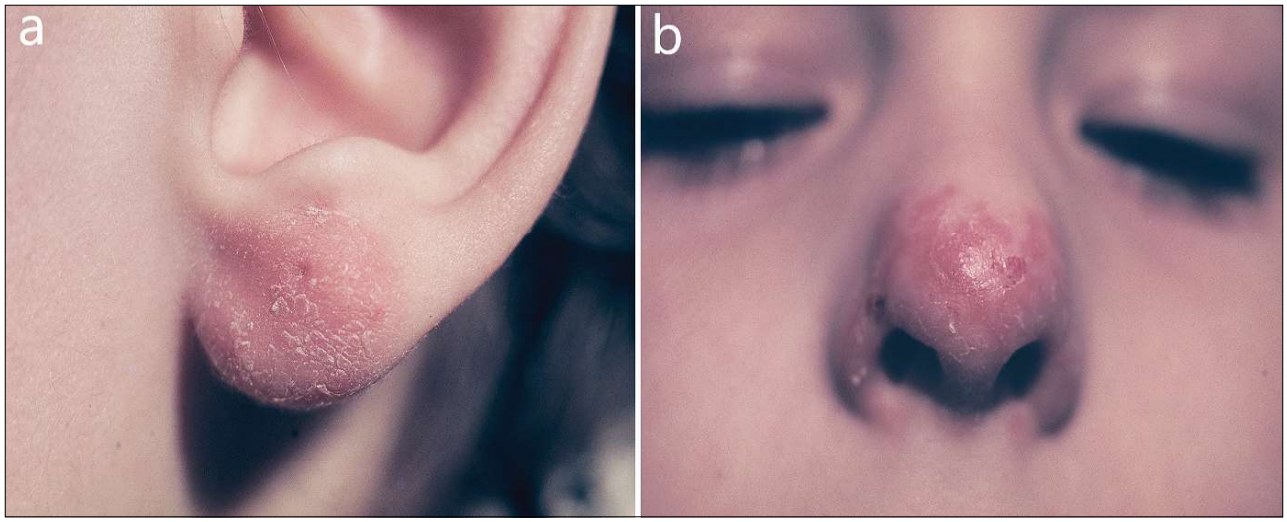

Figure 2. a. Psoriasis of the ear lobe. b. Psoriasis of the tip of the nasal pyramid.

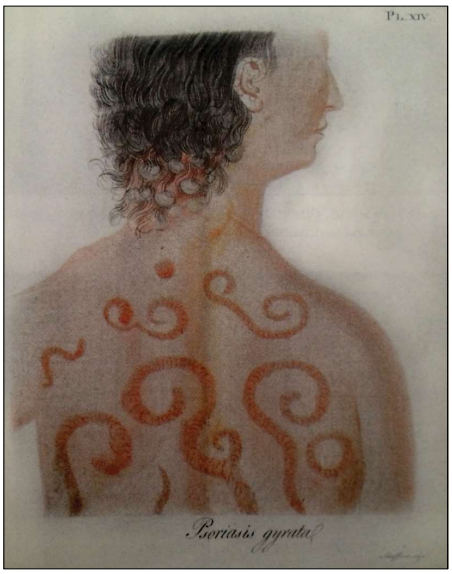

Figure 3. Psoriasis gyrata.

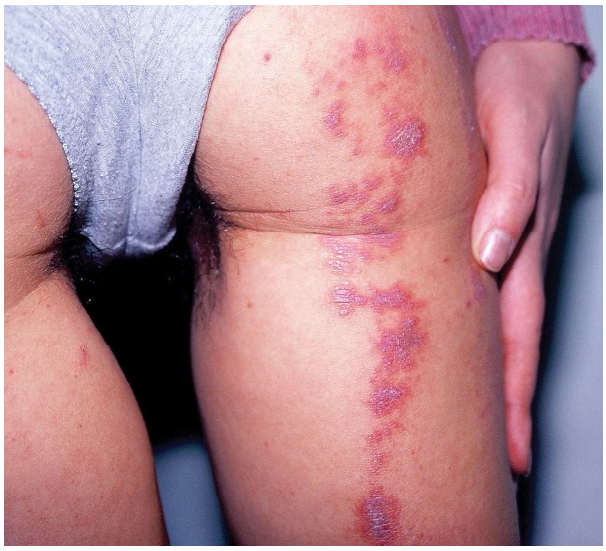

Figure 4. Blaschko-linear psoriasis.

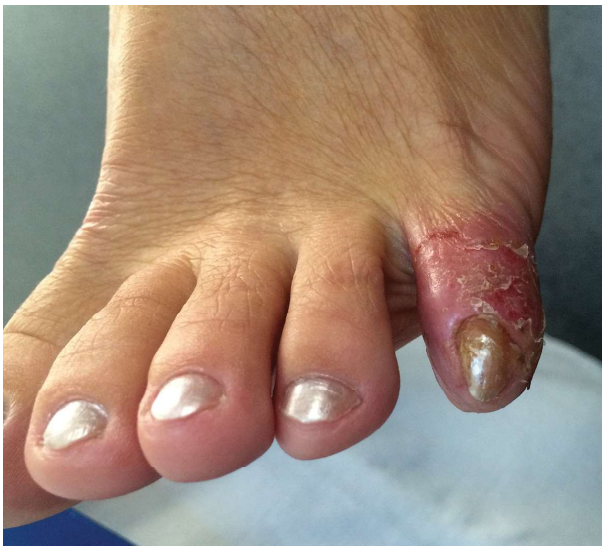

Figure 5. Hallopeau acrodermatitis.

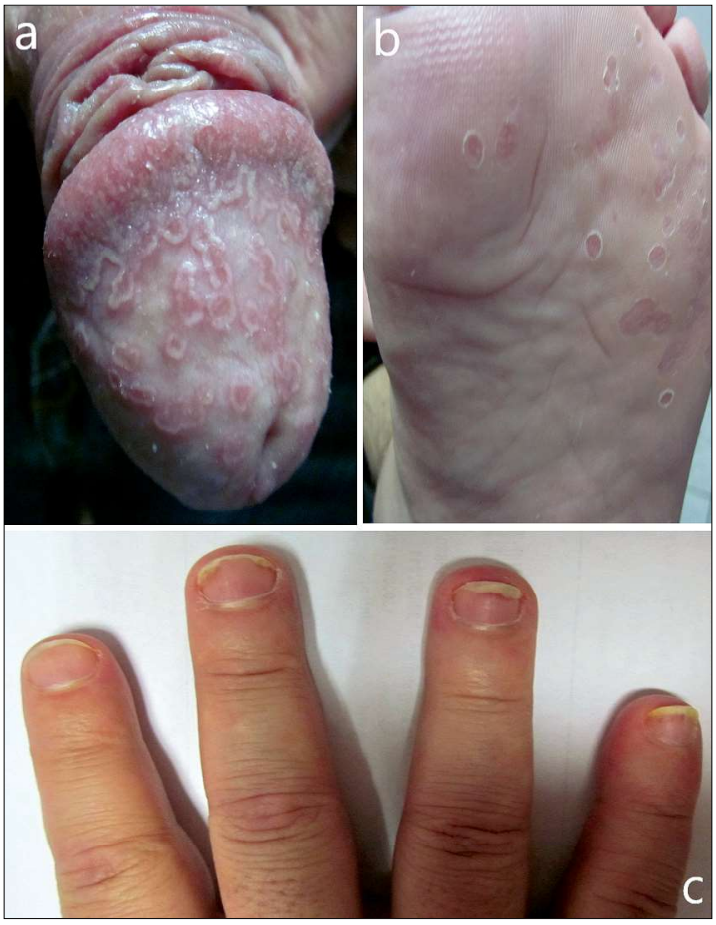

Figure 6. Reiter reactive arthritis: a. Circinate balanitis. b. Keratoderma blennorrhagicum. c. Subungual hyperkeratosis.

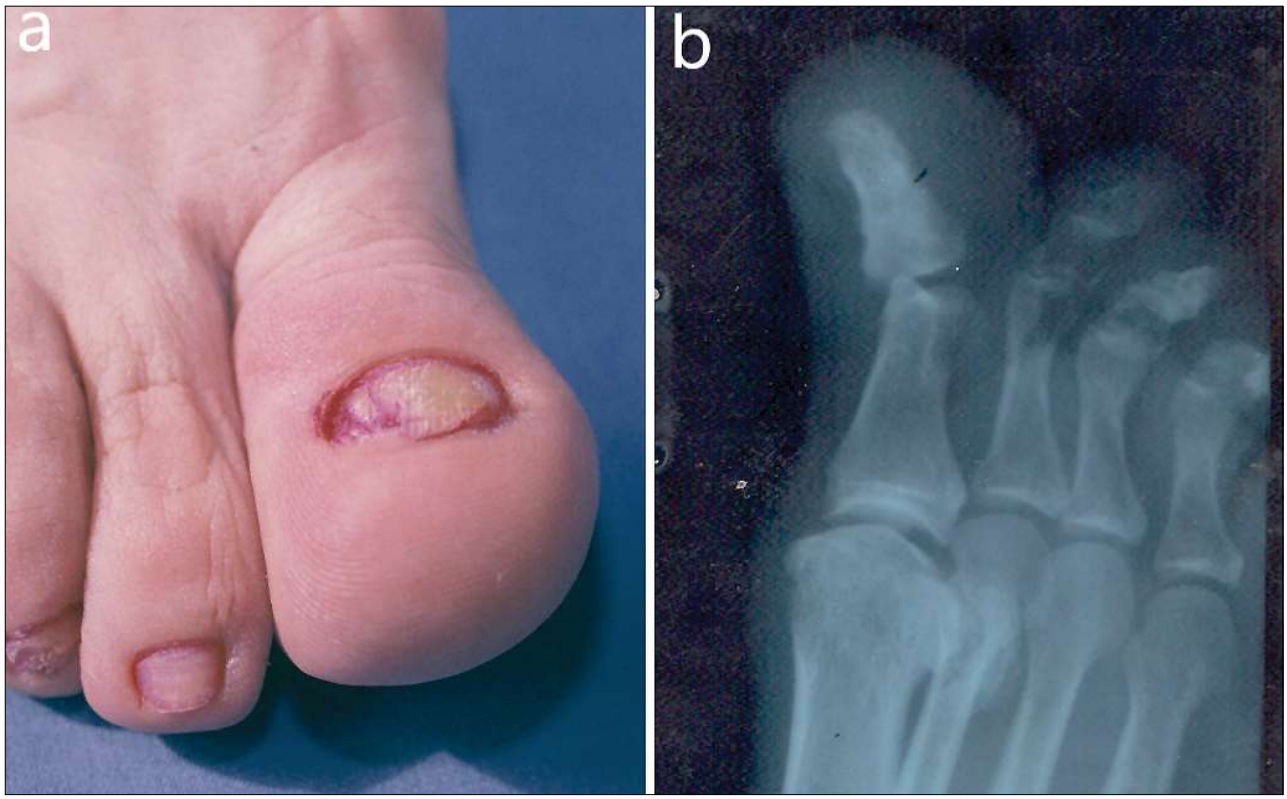

Figure 7. a, b. Psoriatic onycho-pachydermo periostitis of the hallux.

osteoperiostitis of the distal phalanx. According to some authors, the presence of inflammatory and painful enlargement of the soft tissues of the hallux associated with osteo-periostitis of the distal phalanx are sufficient enough to consider the onyxis as psoriatic, without requiring a biopsy. Similarly, the presence of psoriatic onyxis associated with inflammatory and painful thickening of the soft tissues of the distal phalanx raise the suspicion of the presence of osteo-periostitis of the distal phalanx. Clinically, OP3GO is characterized by hallux erythema, usually nonsquamous and without pustules, painful, requiring systemic treatment, as topical treatments cannot resolve the pain and soft tissue inflammation. Radiology reveals swelling of the periarticular interphalangeal soft tissues, without detectable bone lesions or periosteal reactions.

OP3GO could be explained by the existing anatomical relationship between the nail and the enthesis of the distal interphalangeal joint. The differential diagnosis should include Bauer's finger in patients with psoriatic arthritis that associates psoriatic onychopathy, perionyxis and arthritis of the distal interphalangeal joint on the same finger or toe. Also, OP3GO must be differentiated from pachydermoperiostosis or hypertrophic osteoarthropathy characterized by segmental thickening of the skin and bone hypertrophy, the patients having thick fingers with distal extremities resembling „drum sticks", but without psoriatic changes of the nails. The painful thickening of the soft tissues of OP3GO requires a differential diagnosis with gout, and the nail involvement, with onychomycosis [5].

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Conflict of interest
NONE DECLARED

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