Harry's Head

Stanley Wine, MD, FRCPC

Meet Harry

- He is a 20-year-old male who noted a white patch of hair on his scalp six months ago
- He has had a palpable lesion in that area for years

Physical Examination

- There is a visible localized area of gray hair surrounding a speckled, pink nevus

What is your diagnosis?

a) Vitiligo
b) Halo nevus
c) Resolving alopecia areata
d) Melanoma
e) Familial poliosis

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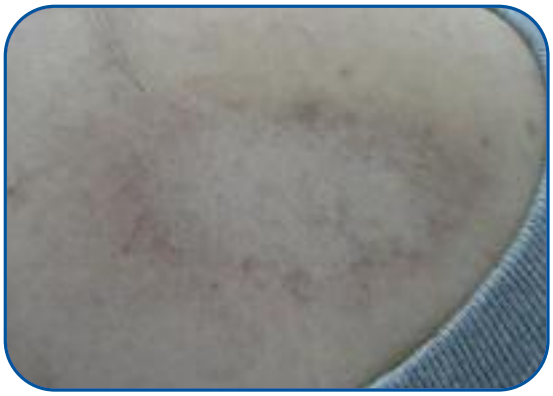
See page 4 for the answer to last month's case

Here is the answer to last month's case

Meet Francine

- Francine is a 34-year-old Asian female with a several month history of a slowly enlarging firm plaque on her back
- The lesion is occasionally pruritic and feels dry and wrinkly to the touch
- Francine has no personal or family history of skin problems
- Francine has hypothyroidism for which she is on medication and is otherwise healthy with no drug allergies



What is your diagnosis?

a) Sclerodema
b) Sclerotic basal cell carcinoma
c) Morphea
d) Lipodermatosclerosis
e) Stiff skin syndrome

Answer: C

Morphea **(answer c)** is a localized scleroderma due to deposition of excessive collagen with resulting thickening of dermal and/or subcutaneous tissues. There are several subtypes, including focal plaque, linear, generalized, and deep morphea; none of these have systemic features of systemic sclerosis.

Most patients (70%) with morphea present with plaque-type morphea, with generalized, linear, and deep variants each making up 10% of cases. As much as half of morphea cases occur in the pediatric population where linear morphea (66%) is the most common type, followed by plaque-type (25%).

Morphea has a benign, self-limited course in most cases with no effect on mortality. Linear and deep morphea can cause considerable morbidity, especially in children where growth may be affected.

Plaque-type morphea is the most common subtype. It is benign, with variants. It predominantly affects the dermis; although, the epidermis is occasionally affected with lichen sclerosus et atrophicus. Morphea lesions are round or oval (in a horizontal direction), indurated plaques from 1 to 20 cm in diameter, and they often begin as erythematous to violaceous patches.

The trunk is most commonly affected, and the face is typically spared. As the lesion expands, sclerosis develops centrally; the surface becomes smooth, shiny and ivory-waxy, and the lesion losses adnexal structures (hair, sweat glands). The margins are typically surrounded by a violaceous zone or telangiectasias.

Although the diagnosis is typically clinical, a biopsy can be useful for confirmation. A deep punch or incisional biopsy including subcutaneous fat is sufficient. Radiography is of benefit for linear or deep morphea if underlying bone involvement is suspected. MRI of the brain and/or EEG may be useful for craniofacial involvement.

Treatment is aimed at reducing the inflammatory activity of the early stages of the disease; treatment of late sclerotic disease is less successful. The natural history of plaque-type morphea involves spontaneous resolution after a few years, and thus, lesions are treated with potent topical or intralesional steroids to halt disease progression and minimize inflammation.

Individuals with deeper, generalized, linear morphea require referral to a dermatologist for consideration of systemic steroids or methotrexate. Phototherapy is another useful option, particularly with the deeper penetrating UVA wavelengths.

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Benjamin Barankin, MD, FRCPC

Congratulations
to our winner for the months of September 2011!
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