



## Large, Brown, Scaling Patches

By Simon Lee, MD, FRCPC

A 45-year-old-healthy male presents to the office with a two year history of an asymptomatic, persistent eruption on the trunk. He was treated with various topical steroid and antifungal creams without improvement.

Examination reveals large brown scaling patches on the trunk measuring up to 5 cm in diameter. There is no lymphadenopathy nor organomegaly. Fungal preparation and culture are negative.

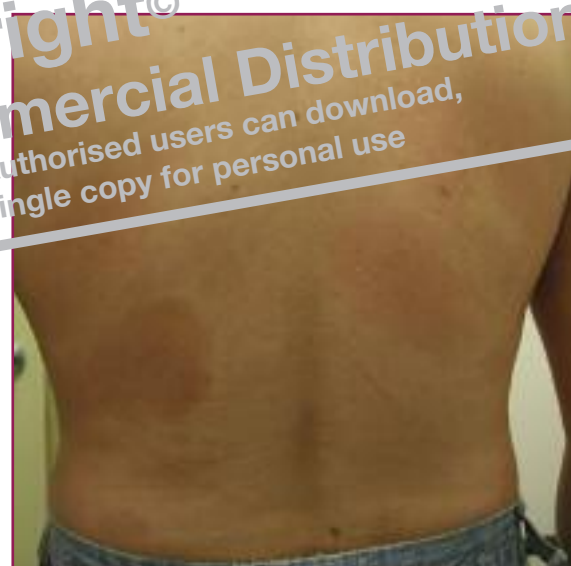
### *What is your diagnosis?*

- a. *Pemphigus vulgaris*
- b. *Idiopathic thrombocytopenia*
- c. *Neurofibromatosis type 1*
- d. *Parapsoriasis*

### *Answer: Parapsoriasis*

Parapsoriasis is an uncommon cutaneous condition characterized by a superficial scaling dermatitis. The original clinical description (Brocq 1902) referred to a group of diverse and unrelated skin diseases that resembled psoriasis. Thus, the clinical descriptive name is somewhat misleading. Current classification places parapsoriasis in the spectrum of T cell lymphocytic disorders of the skin. Parapsoriasis is divided into small (< 5 cm diameter) and large (> 5 cm diameter) plaque types.

The true incidence of parapsoriasis is not known since patients are often asymptomatic and the history vague. Patients tend to present in middle age. The onset of lesions is insidious and



indolent in nature. They gradually enlarge in number and size over months and years. Small plaque lesions may even spontaneously resolve, making the diagnosis more elusive.

Individual lesions are well circumscribed and have surface scaling. They have a light brown to salmon coloured appearance. Often, they are randomly distributed on the trunk and extremities. However, a distinct form, characterized by sinewy, finger-like projections that follow the skin cleavage lines of the body, has been aptly termed digitate parapsoriasis.

Parapsoriasis is a clinical diagnosis based on skin biopsy. Pathology reveals a superficial dermal infiltrate of benign appearing lymphocytes. Immunocytochemistry and molecular investigation demonstrate a predominance of CD4+ T cells. Chronic antigen stimulation has been proposed to explain the inflammatory process. Some studies reveal a high prevalence of herpes simplex 8

virus; although, causality remains to be defined. In large plaque parapsoriasis, a dominant T cell clone may be present in gene rearrangement studies.

In contradistinction, cutaneous T cell lymphoma (CTCL) displays atypical lymphocytes on histology. As our understanding of lymphocytic disorders evolves, a question arises concerning whether parapsoriasis represents an early or transition stage of cutaneous T cell lymphoma (CTCL). Small plaque type parapsoriasis is benign in nature and has an excellent prognosis. However, 10% of large plaque type patients may progress into CTCL.

Treatment should be conservative and based on relief of symptoms, such as pruritus. Overall, the prognosis is excellent, and patients should be reassured as to the benign nature of the disease. In addition to a skin biopsy, a complete blood cell count with smear (to rule out Sézary cells as seen in CTCL) should be performed. Mid-potent to potent steroid cream preparations remain the cornerstone of therapy. In patients with widespread disease, broad or narrow band UVB therapy is effective and may even induce remission. Regular monitoring is mandatory with repeat skin biopsy

of persistent lesions to assess risk for malignant transformation to CTCL, especially in patients with large plaque parapsoriasis. Treatment options include PUVA (oral psoralens combined with UVA therapy), topical nitrogen mustard, as well as carmustine. Even in patients with large plaque parapsoriasis, the five year survival rate is greater than 90%. Thus, patients should be optimistic about a favourable prognosis. Indeed, afflicted patients often succumb to unrelated illnesses.



#### Resources

1. Herzinger T, Degiz K, Plewig G, *et al*: Treatment of Small Plaque Parapsoriasis with Narrow-band (311 nm) Ultraviolet B: A Retrospective Study. *Clin Exp Dermatol* 2005;30(4): 379–381.
2. Hofer A, Cerroni L, Kerl H, *et al*: Narrowband (311-nm) UV-B Therapy for Small Plaque Parapsoriasis and Early-stage Mycosis Fungoides. *Arch Dermatol* 1999;135(11):1377–1380.

**Dr. Simon Lee** is a Dermatologist in Richmond Hill, Ontario.

#### Share your cases with us!

*Our mailing address:* 6500 Trans-Canada Suite 310 Pointe-Claire, Québec H9R 0A5  
*Our fax number:* (514) 695-8554  
*Our e-mail address:* [diagnosis@sta.ca](mailto:diagnosis@sta.ca)