Up Close

A Look at Dermatological Diagnoses

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Psoriasis and Eczema

How do I accurately differentiate psoriasis from eczema?

It is usually easy to distinguish psoriasis from dermatitis, however not always. Both are chronic erythematosquamous skin conditions.

In the patient's history, trigger factors contributing to psoriasis are listed in Table 1. In addition to these factors, 20% to 34% of patients with psoriasis have a seronegative, usually oligo- or polyarticular arthritis.

On physical examination, the clinical differentiation from dermatitis will depend on the type of psoriasis.

The most common form of psoriasis is chronic plaque type with thick well-circumscribed plaques much thicker than what is seen in eczema.

There is a form of neurodermatitis called lichen simplex chronicus which presents with well-circumscribed plaques, caused by chronic rubbing or scratching. The history in these cases will be critical. In most cases, the plaque will be solitary and unilateral. The symmetric distribution of plaques on the extensor surfaces of the elbows, knees, trunk, and scalp are classic symptoms of psoriasis.

In the scalp and intertriginous areas of infants, and the scaling of the scalp and eczematous patches on the forehead and nasolabial folds of adults, seborrheic dermatitis may be difficult to clearly distinguish from psoriasis (hence the term sebopsoriasis).

Table 1
Trigger factors contributing to psoriasis

• genetics: up to 50% have positive family history of psoriasis (increased HLA-Cw6)
• medications: beta blockers, lithium, nonsteroidal anti-inflammatories, withdrawal of corticosteroids
• recent infection: *Streptococcal pharyngitis* or perianal dermatitis
• trauma
• stress

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Up Close

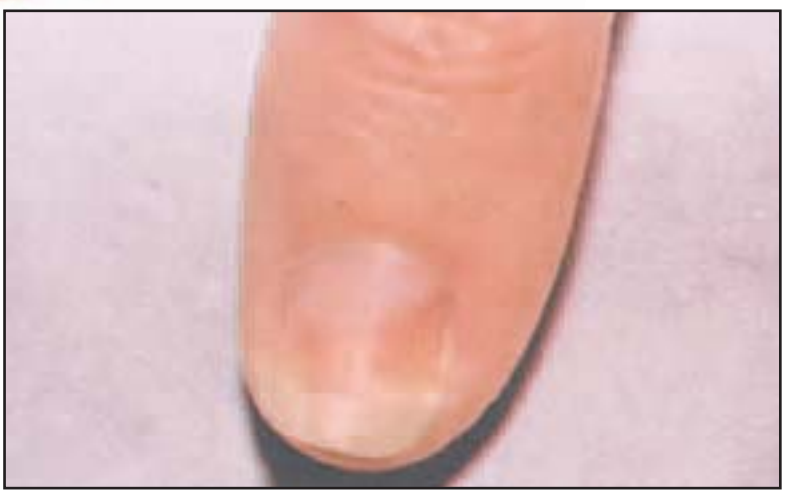

Figure 1. Psoriatic fingernail changes.

Inverse psoriasis may be found in patients who also have plaques, or in the intertriginous areas alone. Bright red well-circumscribed patches are found in the groin, axilla, gluteal fold, and inframammary areas.

The guttate form of psoriasis presents often in young patients, preceded by strep pharyngitis, perianitis, or sunburn. An eruption on the trunk and proximal extremities with fine, oval, 1 cm scaling patches evokes a differential diagnosis of pityriasis rosea, more than nummular eczema.

Localized pustular psoriasis on the palms and soles may mimic dyshidrotic eczema, but usually the pustules are larger in psoriasis, and the background erythematous patch is more sharply marginated.

The erythrodermic patient with generalized erythema may have dermatitis, psoriasis, drug eruptions, neoplasia, or idiopathic.

Nails changes with oil-drop changes, and subungual hyperkeratosis are further characteristics of psoriasis; pitting, strations, splinter hemorrhages, and onycholysis may also be found in cases of eczema (Figure 1).

Of course, skin biopsy can be performed when in doubt. The classic pathology for psoriasis is described in Table 2.

Both dermatitis and psoriasis have a perivascular lymphocytic infiltrate, with intracellular edema of the epidermis (spongiosis). This also occurs in cases of acute dermatitis. CME

Table 2
Classic psoriasis pathology

- thickening of the epidermis (acanthosis) with club-shaped rete ridges
- thickening of the stratum corneum with parakeratosis
- neutrophilic infiltrate through the epidermis
- spongiform pustules of Kogoj
- papillary edema with dilated tortuous blood vessels