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CASE REPORT

Localized Pitiryasis Lichenoides

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Abstract. Pityriasis lichenoides is a papulosquamous disorder of unknown etiology frequently seen in the pediatric population. The lesions are usually widespread on the trunk and extremities, and only exceptional cases of localized forms have been reported. We report a 9-year-old patient with recurrent crops of PL lesions exclusively involving the lower abdomen.

Key words: pityriasis lichenoides, localized distribution, regional form.

PITIRIASIS LIQUENOIDE LOCALIZADA

Resumen. La pitiriasis liquenoide es una enfermedad papulodescamativa de etiología desconocida frecuente en la edad pediátrica. Las lesiones suelen distribuirse de manera difusa en el tronco y las extremidades, y sólo excepcionalmente se han descrito casos de afectación localizada en un área limitada del cuerpo. Presentamos el caso de un niño de 9 años con brotes recurrentes de pitiriasis liquenoide de localización exclusiva en la zona inferior del abdomen.

Palabras clave: pitiriasis liquenoide, distribución localizada, forma regional.

Introduction

Pityriasis lichenoides (PL) is characterized by papulosquamous eruptions normally occurring on the trunk and limbs.[1] Lesions have an intermittent course and tend to leave characteristic residual hypopigmentation. Prognosis is good, although outbreaks can recur for months and even years. We present the case of a 9-year boy with recurrent outbreaks of PL exclusively on the lower abdomen.

Case Description

A healthy 3-year boy, with no personal or family history of interest, was examined in our clinic due to abdominal skin lesions which had appeared 3 months earlier. The skin lesions were asymptomatic, with recurrent outbreaks, leaving residual lenticular hypopigmentation in the areas of regression. The clinical picture remained unchanged after treatment with medium- and high-potency topical corticoids, but improved slightly in areas exposed to sunlight during the summer. Physical exploration showed reddish-brown desquamative erythematous papules, 3 to 5 mm diameter, on the lower abdomen and both sides of the groin. Scaling consisted of a single micaceous scale, which

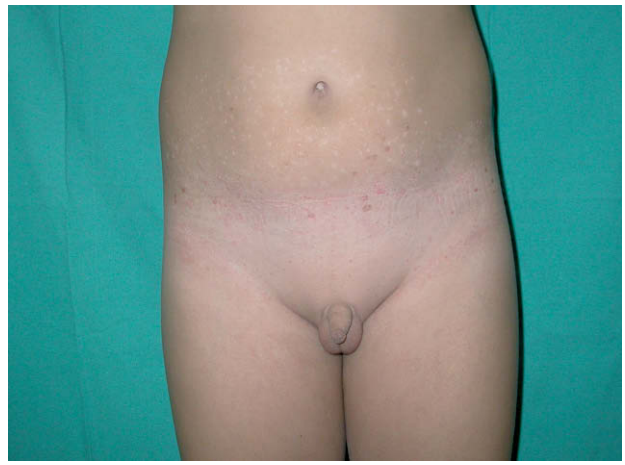

Figure 1. Reddish-brown desquamative erythematous lesions in the lower abdominal region and groin with additional residual leukodermic lesions in the periumbilical area, the latter corresponding to part of the body exposed to sunlight in summer.

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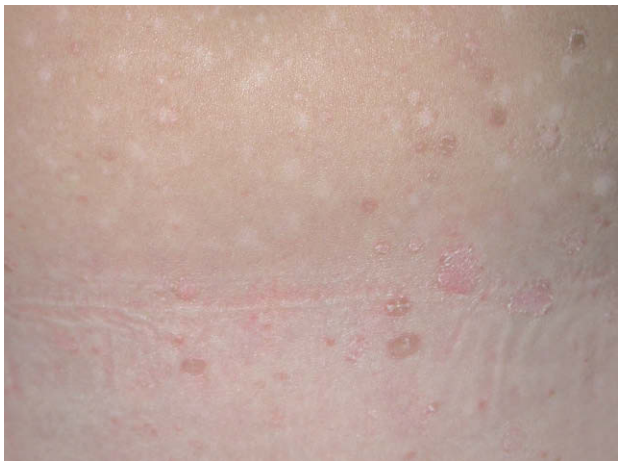

Figure 2. Detail of Figure 1. Lesions with micaceous scale characteristic of chronic phases of pityriasis lichenoides.

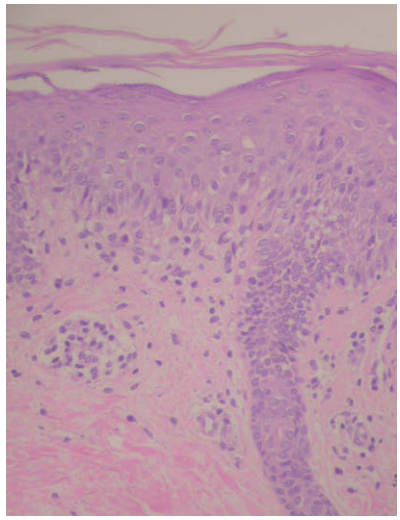

Figure 3. Histological study showing interface dermatitis with necrotic keratinocytes in the basal layer, lymphocytic exocytosis, and a mild inflammatory infiltrate in the superficial dermis (hematoxylin-eosin, × 40).

was easily detached by scratching (Figure 1 and Figure 2). The findings of the rest of the clinical examination were normal. Histological study showed epidermis with irregular acanthosis and extensive areas of confluent parakeratosis. There was mild perivascular lymphocytic infiltrate with focal involvement of the dermal–epidermal junction, exocytosis, and isolated necrotic keratinocytes in the superficial dermis (Figure 3). At present, the patient is 9 years old and continues to present recurrent and self-limiting outbreaks of skin lesions similar to the ones described which are always located on the lower abdominal area. A second biopsy performed in the course of an outbreak demonstrated histological findings similar to the ones described.

Discussion

Our patient presented a skin lesion whose clinical morphology, intermittent evolutionary course, residual hypopigmentation, and response to sunlight suggested a localized form of PL. Moreover, 2 histological studies showed microscopic findings consistent with those of the chronic phase of PL.

Pityriasis lichenoides is a papulosquamous disorder of unknown etiology which is common in the pediatric age group. Initial lesions are papules or papulovesicles that develop into crusted ulcers, then desquamative lesions, and, finally, dyschromic lesions. If inflammation is very severe, varioliform scarring can occur. A single micaceous scale is often observed, which is easily detached by scratching, and there is characteristic residual hypopigmentation that leaves some lesions after regression. Skin lesions can be limited to the trunk (central distribution), the limbs (peripheral distribution), or the trunk and limbs (mixed or intermediate forms).[1] Histological findings show that PL involves interface dermatitis with necrotic keratinocytes, exocytosis of lymphocytes, and dermal extravasation of red blood cells. In acute phases, the inflammatory infiltrate is very dense and can adopt a characteristic V-shaped morphology, whereas in chronic lesions the histological findings characteristic of PL are far less striking, with a much less severe perivascular lymphocytic infiltrate and mild alterations of the dermal–epidermal junction.[2] The disease process is chronic and recurrent, and lesions can be in different phases of development at the same time; duration varies and although in some cases the process lasts for 6 to 8 weeks, it usually continues for months and even years.[1]

Localized forms of PL are exceptional. Isolated cases have been reported of patients with exclusively acral lesions,[3,4] and we have only found 1 published case of focal PL on the trunk.[5] In the former cases, the acral lesions were located on the distal upper limbs[3] or distal lower limbs,[4] whereas in the latter case only parts of the left hemithorax were involved.[5] The diagnosis of a localized form of PL was supported by clinical and histological findings, the intermittent course of the lesions, and good response to psoralen plus UVA therapy[3] or exposure to sunlight.[5] To date, no etiopathogenic theory can explain the focal nature of the disease process. Likewise, it is not known why other inflammatory processes, such as psoriasis, lichen planus, lymphomatoid papulosis, or secondary syphilis, can present exclusively localized disease.[3,6-8] The differential diagnosis of localized PL from the diseases mentioned is based on clinical and histological findings which tend to be characteristic of PL.

We do not know the pathophysiological mechanism responsible for restricting the lesions to such a limited

area of our patient's body, where all the clinical and histological findings are consistent with those of localized PL. Although over a 6-year period the patient has not developed lesions outside this area, we have continued follow-up as subsequent spread of the disease or even a future association with other types of lymphoproliferative disease cannot be ruled out.

Conflicts of Interest

The authors declare no conflicts of interest.

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