INVESTIGATIVE REPORT

Non-invasive Imaging of Localised Scleroderma for Assessment of Skin Blood Flow and Structure

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Extensive morphea causes major morbidity, disability and disfigurement; pathophysiology is poorly understood. The aim of this study was to investigate, with non-invasive imaging, the relationship between localised abnormalities of skin structure and perfusion, which characterise morphea. Thirty-two patients with morphea underwent imaging at affected and unaffected sites.

Skin thickness was imaged with optical coherence tomography (OCT) and high-frequency ultrasound (HFUS). Perfusion was imaged with dual-wavelength laser Doppler imaging (LDI) and thermography. Epidermal thickness showed a small increase from affected to unaffected site (OCT, active and inactive plaques \( p = 0.005 \) and \( p = 0.004 \), HFUS active plaques only \( p = 0.03 \)). Deeper perfusion was higher within affected than unaffected sites (LDI \( p < 0.001 \), thermography \( p < 0.0001 \), active and inactive plaques). Epidermal thickness was inversely related to superficial (but not deeper) perfusion. This novel study of OCT, HFUS, LDI and thermography confirms loss of epidermal thickness and increased deeper perfusion in morphea plaques. Key words: morphea; scleroderma; imaging; perfusion; skin thickness.

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Morphea (localised scleroderma) refers to thickening and tightening of the skin and underlying tissues (1, 2). Active lesions show increased angiogenesis resulting in erythema and increased blood flow as compared to surrounding skin (2). Inactive plaques tend to show lower blood flow. The relationship between both the fibrotic and vascular components of the skin in active and dormant morphea needs to be elucidated. In some patients, morphea can be extensive and a cause of major morbidity, disability and disfigurement. There is a need to increase our understanding of the pathophysiology of morphea in order to identify key targets for therapeutic intervention, because current treatments are far from ideal. The aim of this study was to investigate the relationship between increased blood flow and the localised abnormalities of skin structure which characterise morphea.

PATIENTS AND METHODS

Patients with a confirmed diagnosis of plaque morphea were recruited into the study. One plaque was measured for each patient; if more than one plaque was present the newest and most active plaque was selected. The duration, location and status (active/dormant as assessed by the patient) of the imaged plaques were noted by the observers taking measurements (TM, GD). All patients gave written consent. The study was approved by National Research Ethics Service North West Committee.

All measurements were made in a low-lit, temperature controlled laboratory (23ºC). All participants were asked to refrain from caffeine and nicotine for 4 h before the study and were acclimatised for 20 min before imaging.

Techniques for assessment of skin structure

Skin structure was measured using two imaging techniques; optical coherence tomography (OCT) and high frequency ultrasound (HFUS). OCT (Fig. 1a) is a relatively new light-based imaging technique analogous to ultrasound (3). A Thorlabs OCM 1300 SS (Thorlabs Inc. NJ USA, 1300 nm), which images into the skin up to approximately 2 mm at a resolution of approximately 7 microns was used to take B scans of skin (epidermis only).

HFUS (Fig. 1b) is an established technique for measurement of skin thickness in patients with SSC (4). The EPISCAN–I-200 system (Longport Inc., PA, USA; 35 MHz) used has a resolution of 40 µm. HFUS penetrates more deeply than OCT (up to approximately 3 cm) allowing measurements of both epidermis and dermis to be taken. OCT and HFUS are therefore complementary techniques: OCT has the advantage of very high resolution but low penetration, whereas HFUS has higher penetration but lower resolution.

Techniques for assessment of skin blood flow

Blood flow was assessed directly by laser Doppler imaging (LDI) (Fig. 1c) and indirectly by skin temperature (thermography; Fig. 1d). The dual wavelength LDI used is a modified MoorLDI (Moor Instruments, Axminster, UK; as described previously [5]) and uses low power scanning lasers (red wavelength laser, 633 nm and green wavelength laser, 532 nm) to image two layers of superficial skin blood flow (red laser; deeper, larger vessels and green laser; superficial, smaller vessels).

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Thermography is the process of imaging infra-red radiation (heat) emitted by the body. Skin temperature has been shown to be representative of a combination of both superficial skin and deeper muscular blood flow within tissue (6). Images were taken with an Agema Thermavision 570 (FLIR, Kent, UK).

**Areas of interest**

These were defined as shown in Fig. 1c–e at the centre of the plaque, on the inside and outside edges of the plaque and at a site away from the plaque (10 cm).

**Image analysis**

For OCT and HFUS, 3 measurements were taken across the image to provide a mean thickness (µm). OCT images were analysed using a bespoke Matlab (MATLAB version R2012a, Mathworks Inc., MA, USA) interface and analysis routine which allowed the layers of the skin to be manually identified and marked up. In both OCT and HFUS the skin’s surface appears as a hyper-reflective (bright) layer; the dermal–epidermal junction (DEJ) as hypo-reflective (dark band of pixels) and then the dermis below as a second hyper-reflective layer. For OCT epidermal thickness was recorded (number of pixels) as shown in Fig. 1a (including the dark band of the DEJ) and as described elsewhere in the literature (7–10). Pixel-distance calibration was determined from a sample of known size and the same optical density as skin. Epidermal and dermal thickness measurements were extracted for HFUS using EPISCAN Ultrasound scanner software version 4.0.0.030 (Longport Inc., Silchester, UK). For HFUS epidermis was measured as shown in Fig. 1b as previously described (including the DEJ) (4). In HFUS images the whole of the dermis can be observed. The lower boundary of the dermis is marked by a dark, hypo-reflective layer. The dermis was measured as the total depth of the second hyper-reflective layer (as shown in Fig. 1b). For LDI mean blood flow (arbitrary perfusion units, moorLDLS Research, version 5.0D (Moor Instruments) was taken at each site using a standardised area of interest for each subject (as shown in Fig. 1c [arrows] and 1e). For thermography mean skin temperature (ºC) over a standardised area was extracted on Agema Research, version 2.1 (FLIR, Sweden) as shown in Fig. 1d [arrows] and 1e. Thus for each plaque one measurement at each site was generated for each imaging technique.

**Statistical analysis**

Linear mixed effects modelling was used to investigate the difference in blood flow and skin thickness across the sites, as well as the relationship between blood flow and skin thickness. A patient-specific random term was used to account for the multiple observations on each person. Interaction terms were used to investigate whether the relationship between skin thickness and blood flow varied across the sites. A 5% significance level was used throughout. Analysis was conducted in Stata version 12 (11).

**RESULTS**

**Patients**

Thirty two patients took part in the study (5 [16%] male; median age 39.5; interquartile range 28.4–61.4 years; duration and location of the plaques are shown in Table I. Of the 32 plaques 15 (47%) were classed as active (n = 15) and inactive (n = 17) morphoea plaques (frequencies and percentages given) and anatomical location of morphoea in the 32 patients studied. The plaques were classified into four groups based on duration: plaques with duration less than 5 years, 5–10 years, 10–15 years, and those with duration greater than 15 years. The plaques were also classified based on their location: head (en coup de sabre) or face, chest, abdomen, posterior trunk, upper limb, and lower limb. The number of plaques in each group was as follows: plaques with duration less than 5 years (n = 13) had 6.7% active plaques, 3.5% plaques with duration 5–10 years (n = 8) had 3.5% active plaques, 5.2% plaques with duration 10–15 years (n = 7) had 3.5% active plaques, and plaques with duration greater than 15 years (n = 4) had 3.1% active plaques. The plaques were also classified based on location: plaques on the head (en coup de sabre) or face (n = 3) had 9% active plaques, plaques on the chest (n = 1) had 3% active plaques, plaques on the abdomen (n = 8) had 25% active plaques, plaques on the posterior trunk (n = 8) had 25% active plaques, plaques on the upper limb (n = 6) had 19% active plaques, and plaques on the lower limb (n = 6) had 19% active plaques. The plaques were further classified based on anatomical location: plaques on the head (en coup de sabre) or face (n = 3) had 9% active plaques, plaques on the chest (n = 1) had 3% active plaques, plaques on the abdomen (n = 8) had 25% active plaques, plaques on the posterior trunk (n = 8) had 25% active plaques, plaques on the upper limb (n = 6) had 19% active plaques, and plaques on the lower limb (n = 6) had 19% active plaques.

<table>
<thead>
<tr>
<th>Duration of plaque</th>
<th>Percentage active (%)</th>
<th>Inactive/active, n</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 5 years</td>
<td>13 (41)</td>
<td>6:7</td>
</tr>
<tr>
<td>5–10 years</td>
<td>8 (25)</td>
<td>3:5</td>
</tr>
<tr>
<td>10–15 years</td>
<td>7 (22)</td>
<td>5:2</td>
</tr>
<tr>
<td>&gt; 15 years</td>
<td>4 (13)</td>
<td>3:1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Location</th>
<th>Percentage active (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head (en coup de sabre) or face</td>
<td>3 (9)</td>
</tr>
<tr>
<td>Chest</td>
<td>1 (3)</td>
</tr>
<tr>
<td>Abdomen</td>
<td>8 (25)</td>
</tr>
<tr>
<td>Posterior trunk</td>
<td>8 (25)</td>
</tr>
<tr>
<td>Upper limb</td>
<td>6 (19)</td>
</tr>
<tr>
<td>Lower limb</td>
<td>6 (19)</td>
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</tbody>
</table>

Table 1. Duration of active (n = 15) and inactive (n = 17) morphoea plaques (frequencies and percentages given) and anatomical location of morphoea in the 32 patients studied.

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Acta Derm Venereol 96
as active. Three patients had systemic sclerosis in addition to morphoea.

**Skin thickness**

Epidermal thickness showed a small but statistically significant increase moving from the centre of the plaque to the uninvolved site when measured by OCT (for both active and inactive plaques $p=0.005$ and $p=0.004$ respectively) and HFUS (for active but not for inactive plaques $p=0.03$ and $p=0.11$, respectively). Dermal thickness as measured by HFUS showed no significant differences between areas of interest (Fig. 2a–c).

**Blood flow**

Deeper blood flow increased moving from the uninvolved site to the centre of the plaque for measurements taken with the red LDI ($p<0.001$ for both active and inactive plaques) and thermography ($p<0.0001$ for both active and inactive plaques) but not superficial blood flow as measured by green LDI ($p=0.63$ and $p=0.95$ for active and inactive plaques respectively) (Fig. 2d, e).

**Relationships between skin thickness and blood flow**

No associations were observed between HFUS dermal measurements and red LDI and thermal imaging (representing deeper blood flow, $p=0.76$ and $p=0.72$, respectively), and this lack of association was consistent across the sites. Looking for associations between OCT and HFUS epidermal measurements and green LDI (representing superficial blood flow), perfusion measured with green LDI decreased as epidermal thickness increased when using HFUS measurements ($p=0.04$) but not when using OCT measurements ($p=0.29$). Again, these relationships did not vary across the sites.

**DISCUSSION**

The aim of this study was to learn more about the relationship between fibrosis and vascularity in morphoea plaques. Increased perfusion in morphoea plaques may be due to: Changes in the vasculature within the plaque; changes in the cutaneous layers above or surrounding those vessels (decreased thickness may make blood flow easier to image as vessels are closer to the skin’s surface or changes to skin may affect the skin’s optical properties, making it less opaque to light); or a combination of both. Our finding of increased perfusion in morphoea plaques is consistent with our previous work and that of others (12–17). Increased blood flow was more marked in larger (deeper) rather than in smaller (superficial) vessels, suggesting that vascular changes due to morphoea preferentially affect...
larger vessels, rather than capillaries. It also suggests that there are changes to these vessels, rather than this being due solely to their proximity to the skin’s surface. That increased perfusion was found in both active and inactive plaques suggests that microvascular changes may be permanent and therefore may be structural rather than functional.

Epidermal thickness was reduced at the centre of the plaque as compared to the uninvolved skin as measured by OCT (both active and inactive plaques) and HFUS (active plaques only). This suggests that OCT may be more sensitive due to increased resolution. No dermal thickness differences were observed between affected and unaffected sites, possibly implying that surface layers are more involved. That epidermis was thinner in the centre of the plaque adds further weight to the suggestion that the observed increase in deeper blood flow/skin temperature may be multifactorial, and at least in part, due to the increased blood flow/heat conduction from deep tissue through epidermis which has atrophied.

Several studies have been carried out to image morphoea, however they have measured either skin thickness or perfusion (12–18). The novelty of this study lies in the investigation of morphoea plaques with a combination of techniques to examine the inter-relationships between dermal and epidermal thickness and blood flow.

The limitations of this study were the small patient numbers and that our study was cross-sectional and could not therefore address causation. Taking data bilaterally, where, for example, a limb was involved may provide extra data to assess differences from baseline in future studies. OCT techniques have now improved, allowing ‘angiography’ of cutaneous vessels to be performed and this would be of interest in order to assess whether increased blood flow is due to functional or structural changes in vessels. Now that these imaging techniques have demonstrated a relationship between dermal and epidermal thickness and blood flow/skin temperature what are now required are larger, longitudinal studies to clarify the relation of techniques to examine the inter-relationships between dermal and epidermal thickness and blood flow.

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The authors declare no conflicts of interest.

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