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Pityriasis Lichenoides Chronica with Acral Distribution Mimicking Palmoplantar Syphilid

Sir,

Pityriasis lichenoides chronica (PLC) is an idiopathic dermatosis consisting of recurrent crops of erythematous, scaly papules, which exhibit histopathological features of an interface dermatitis, often with many necrotic keratinocytes. The trunk and proximal parts of the limbs are preferentially affected. We describe here a case of PLC involving only acral areas, mimicking palmoplantar syphilid.

CASE REPORT

A previously healthy 31-year-old Korean man developed asymptomatic reddish-brown scaly papules on his palms in December 1997. The lesion subsequently spread to the dorsa of the hands, the soles of the feet and distal parts of the limbs. He visited our department 1 month after the onset of skin eruptions. There was no relevant family history and the patient was not on any regular medication. On physical examination, there were crops of round, reddish-brown papules covered by dry mica-like scales. Some of them were crusted in the centre and older ones were flatter in appearance (Fig. 1). Laboratory investigations including VDRL and TPHA were within normal limits. The biopsy specimen of a papule revealed hyperkeratosis, focal parakeratosis, moderate acanthosis with elongation of rete ridges and superficial perivascular infiltrates. Higher magnification showed a few necrotic keratinocytes, moderate lymphocytic exocytosis, spongiosis and vacuolization of the basal layer of the epidermis. Extravasated red blood cells were also noted in both the epidermis and the papillary



Fig. 1. Crops of round, reddish brown papules covered by dry mica-like scales on the palm and distal parts of the arm.

dermis. These clinical and pathological features led us to make a diagnosis of PLC. The patient was treated with psoralen photochemotherapy (PUVA). After 21 treatments over 7 weeks, the lesions cleared leaving some hyperpigmentation. His palmar lesions recurred, however, 2 months after discontinuation of the PUVA therapy.

DISCUSSION

Although a few cases of PLC with palmoplantar involvement have been described in the literature, PLC affecting the palmoplantar area and distal parts of the limbs without involvement of the trunk, as seen in this patient, is rare (1, 2). Moreover, our patient is unique since eruptions developed on the palmoplantar areas and then spread to the distal parts of his extremities.

Clinical differential diagnosis of PLC includes secondary syphilis, guttate psoriasis, lichen planus, drug eruption, insect bite, lymphomatoid papulosis, pityriasis rosea and papular eczematous dermatitis. Because our patient showed papulosquamous eruptions on the palmoplantar areas, which did not affect the trunk, a diagnosis of papulosquamous palmoplantar syphilid was considered on the first visit. However, negative results of serological tests for syphilis and characteristic pathological features supported the diagnosis of PLC.

Phototherapy has been considered as the first line of therapy in PLC (3). Our patient initially responded well to PUVA therapy.

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