PAPULOSQUAMOUS DISEASE

السلايدات كافيه كمرجع للمذاكره

كلام الدكتور

☺

LEARNING OBJECTIVES:

- Define the *papulosquamous disease*
- Highlight on the pathogenesis of papulosquamous diseases
- Discuss the clinical features of papulosquamous diseases
- Highlight on the papulosquamous diseases treatment

Papulosquamous Disease:

- The term *squamous* refers to scaling that represents thick stratum corneum and thus implies an abnormal keratinization process → in *papulosquamous diseases the normal shedding is lost and more and more skin layers generated leading to thinking of the corneum and it lead to scaling* تقشر

Normal shedding: the normal process of skin renewal every period of time (it occur at the upper layer of the epidermis)

PAPULOSQUAMOUS DISEASES:-

- PSORIASIS
- Pityriasis rosea
- Lichen planus
- Seborrheic dermatitis
- Pityriasis rubra pilaris
- Secondary syphilis
- Miscellaneous mycosis fungoides, discoid lupus erythematosus, ichthyoses

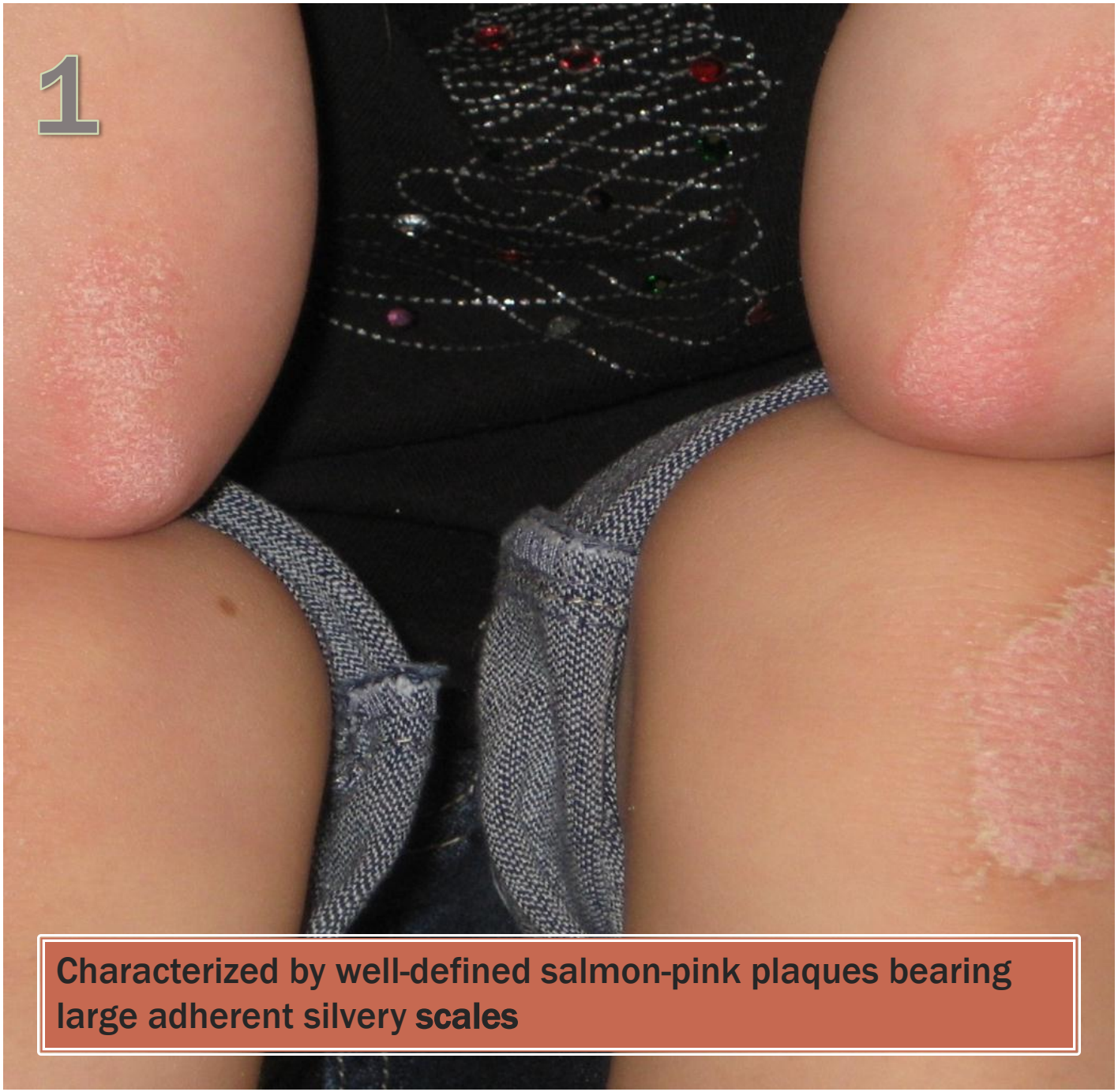
1. PSORIASIS

DEFINITION مهم جدًا

- **Psoriasis is a common, chronic يبقى طول العمر, non-infectious, inflammatory skin disease.**
- **Characterized by well-defined salmon-pink plaques bearing large adherent silvery scales مهمه**
- **Which affects the skin and joints (مهمه)**
- **Causes rapid skin cell reproduction resulting in red, dry patches of thickened skin**

CLINICAL FEATURES OF PSORIASIS

The pictures are examples of clinical manifestations

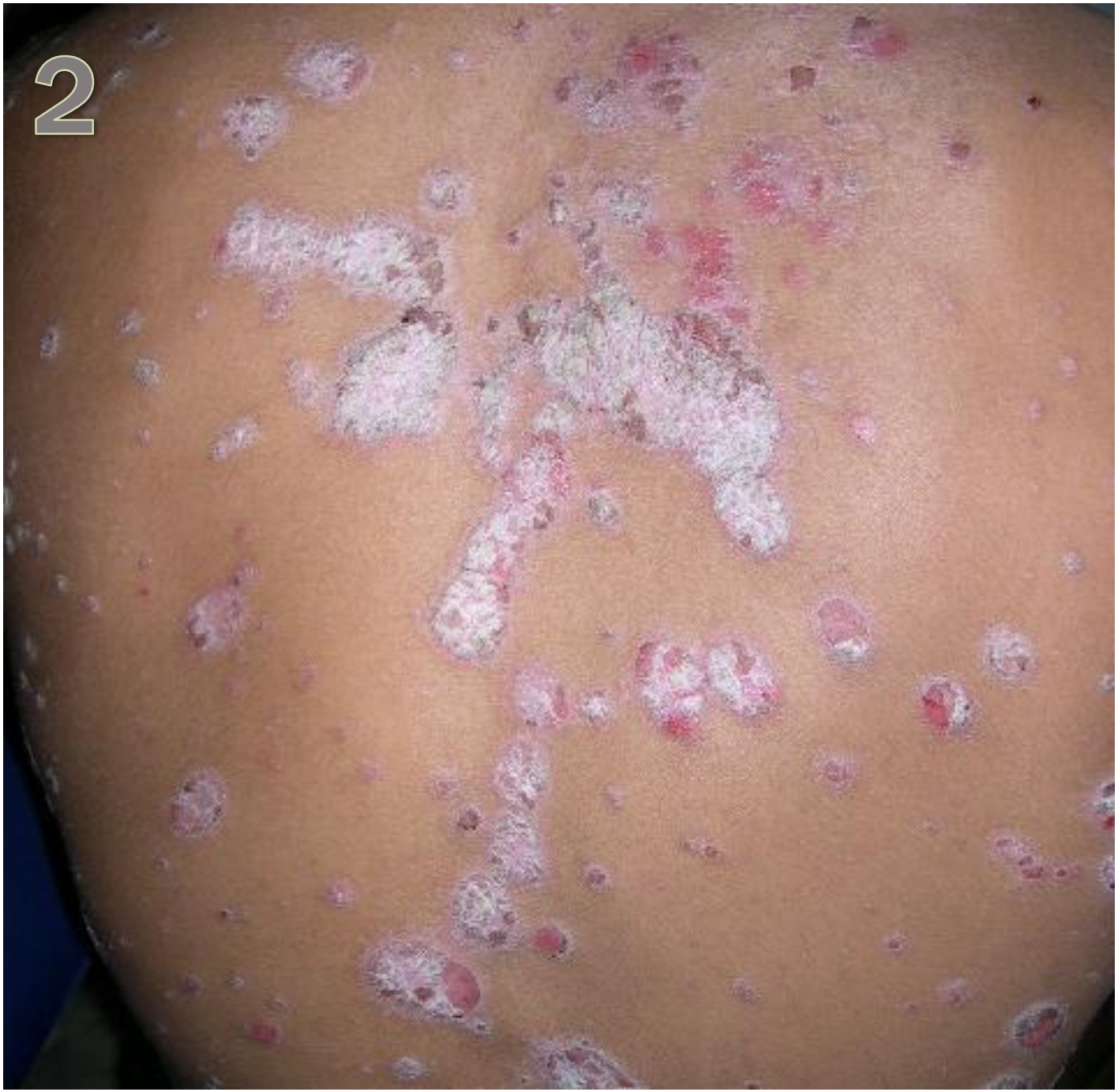


Characterized by well-defined salmon-pink plaques bearing large adherent silvery **scales**

LESION DESCRIPTION

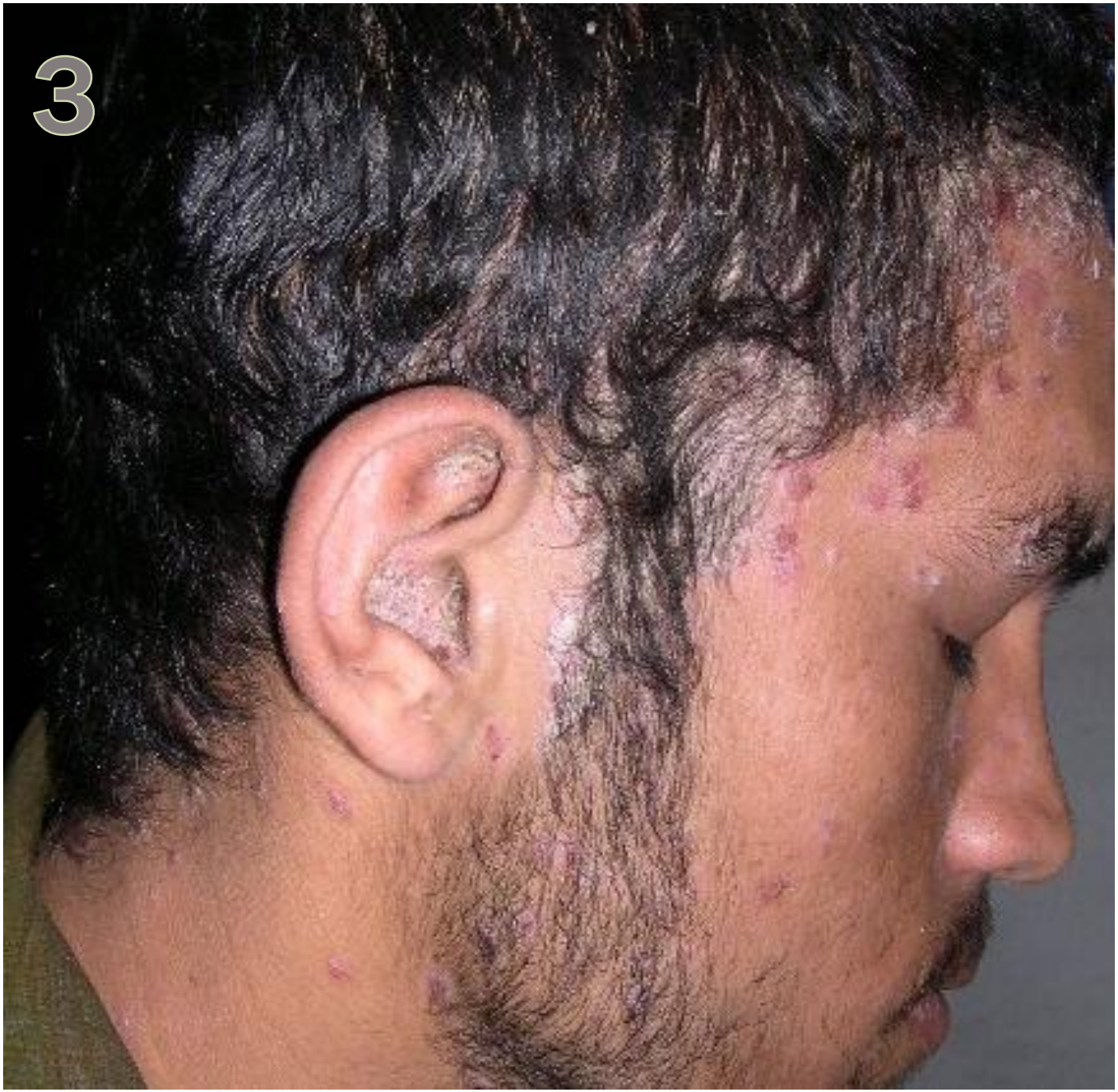
مثال عملي على كيفيه الوصف – طبقه على اي صوره

1. No. / Multiple
2. Borders/well define تستطيع رسم خط بين الجزء السليم والجزء اللي فيه المرض
3. Color/dull erythematous
4. Surface/scaly – other : ulcerated – crusted – pigmented – liquefied
5. Symmetrical
6. Describe the lesion: papule
7. Location/on both elbows and knees



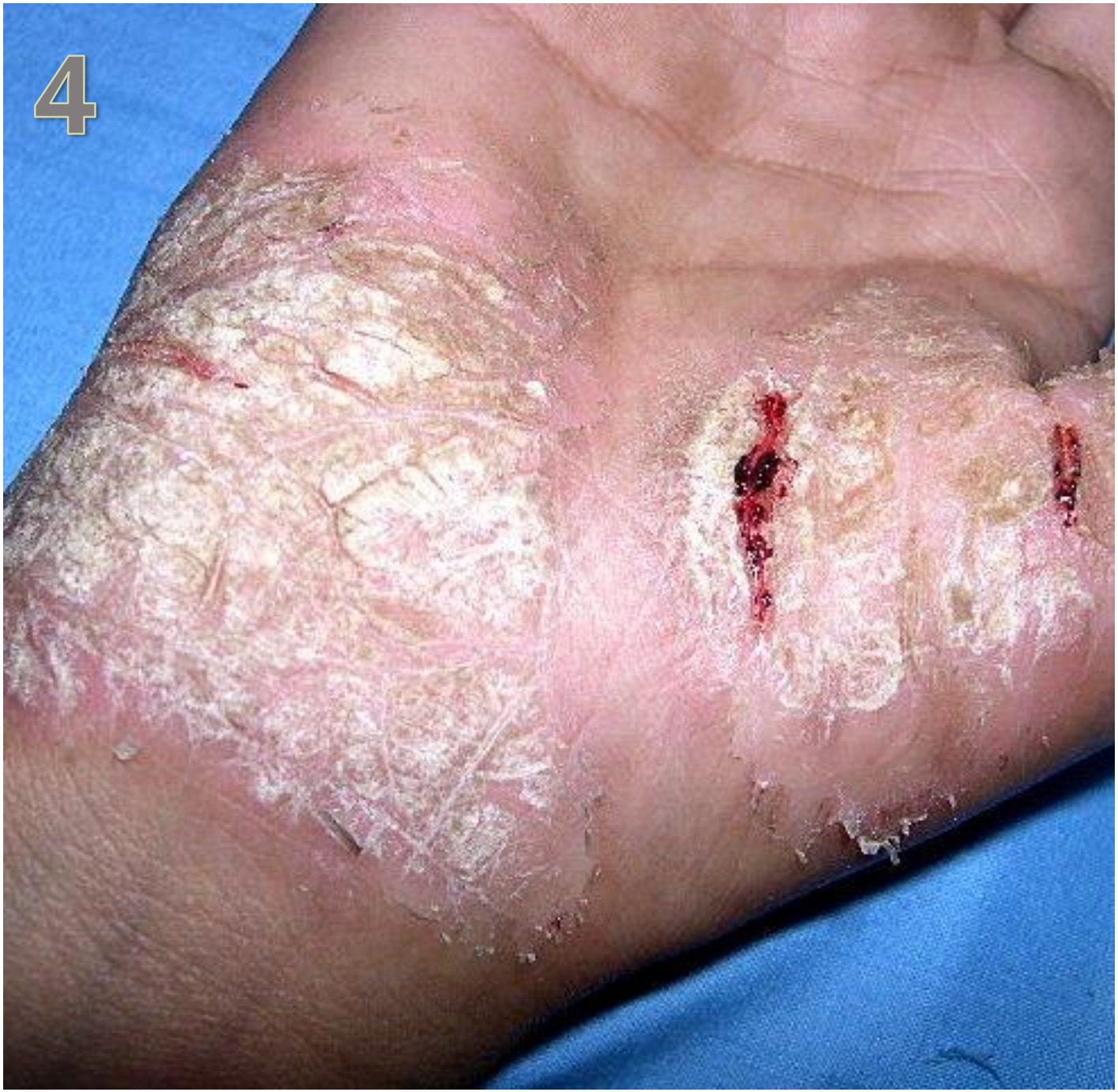
LESION DESCRIPTION

Multiple well define dull erythematous scaly papules and plaques distributed over the back



LESION DESCRIPTION

Well-defined salmon-pink plaques bearing large adherent silvery scales



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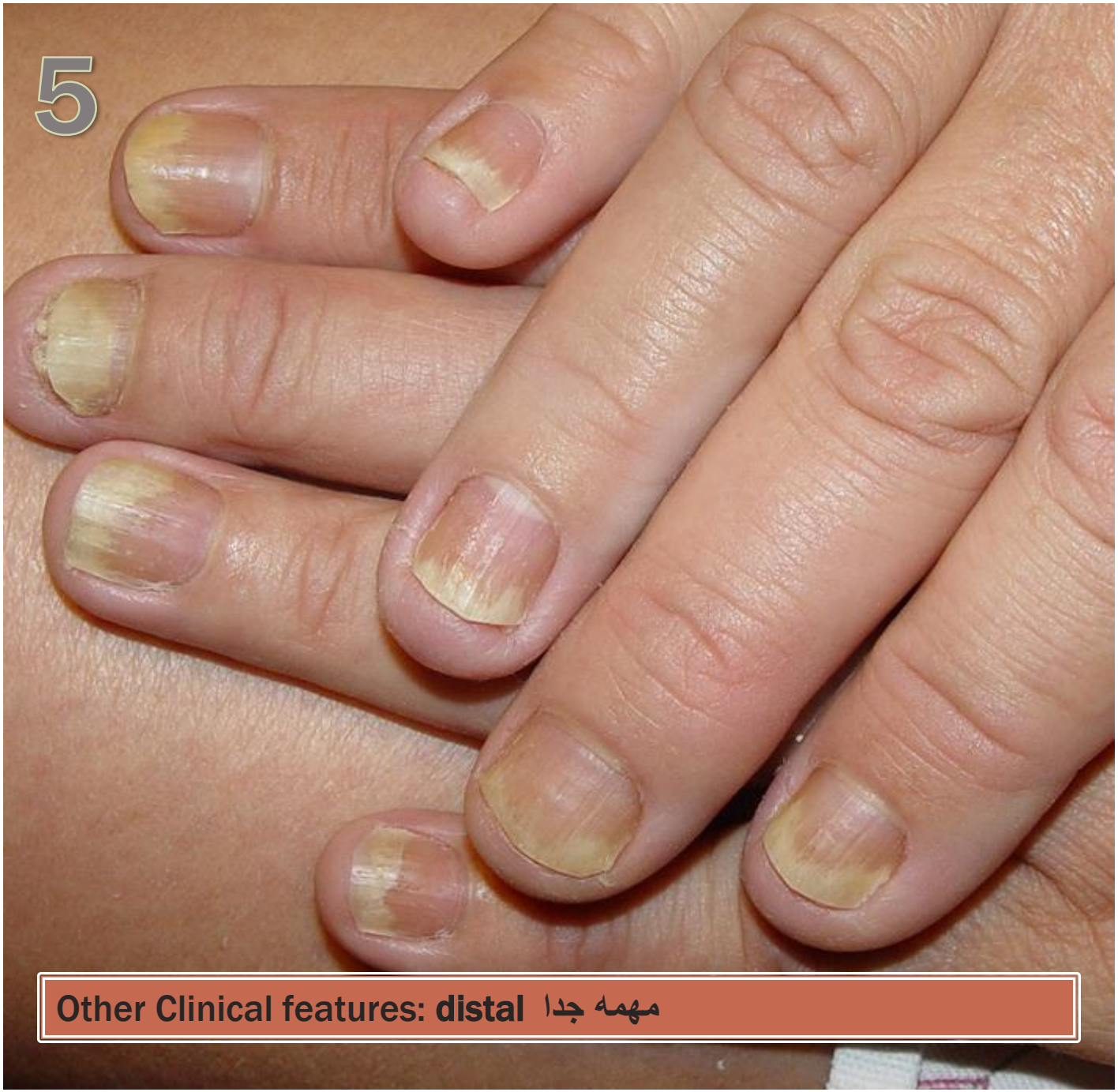


Other Clinical features: **distal** مهمه جدا

LESION DESCRIPTION

1. Distal onycholysis (the distal part of the Nail Plate is separated from the Nail Bed) → special characteristic of Psoriasis
2. Nail pitting (depression)
3. Yellowish brown spots on the nails
4. Accumulation of scales under the nail plate (Subungal Hyperkeratosis)

INCIDENCE AND ETIOLOGY

- The cause of PS still unknown
- Prevalence: 1-3%
  - Under-estimate: because patients with mild psoriasis may not need medical help and because patients who go to family doctors are usually not registered
- F=M
- Any age
  - Two peaks of onset
    - 1) Young at 20s
    - 2) Old at 50s and 60s
- Race: any race; however, epidemiologic studies have shown a higher prevalence in western European and Scandinavian populations.
- One third of patients have a positive family history

PSORIASIS: PATHOGENESIS

- Exact cause is unknown
- Multifactorial

النسب مهمة

A. GENETIC FACTORS

- Psoriasis is a multi factorial disease with a complex genetic trait
- There are two inheritance mode
  - One has onset in younger age with family history of psoriasis
  - The other has onset in late adulthood without family history of psoriasis
- A child with one affected
  - Parent >16%
  - Both parents >50%
- Non-psoriatic parents with affected child>10%
- Monozygotic twins>70%
- Dizygotic twins>20%
- At least 9 loci have been identified (psors- 1 to 9)

B. EPIDERMAL CELL KINETICS

- The growth fraction of basal cells is increased to almost 100% compared with 30% in normal skin

مهمه – عدد الخلايا القابله للانقسام يكون 100% بدلا من 30% لذلك تظهر القشور

- the epidermal turnover وقت التجدد والتغير time is shortened to less than 10 days compared with 30 10 60 days in normal skin

مهمة

C. INFLAMMATORY

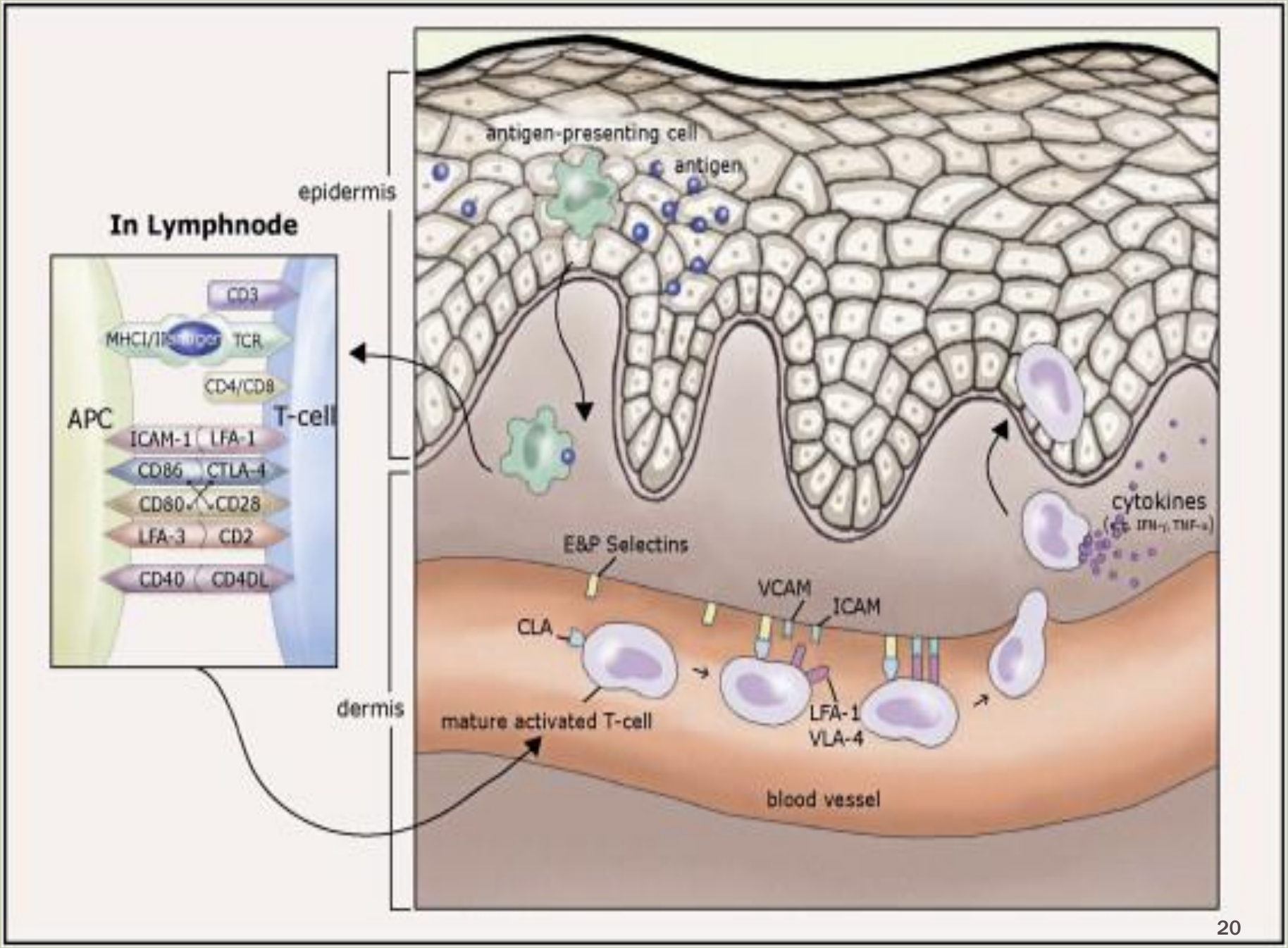
- Increase level of TNF
- TNF receptors are up-regulated
- Increase level of interferon gamma
- Increase level of interleukin 2 and 12
- TNF will cause increase migration of leukocytes into the skin

D. IMMUNOLOGICAL FACTORS

- Psoriasis is fundamentally an inflammatory skin condition with reactive abnormal epidermal differentiation and hyper proliferation
- The inflammatory mechanisms are immune based and most likely initiated and maintained primarily by T cells in the dermis مهمه جدا
- CD8 cells are seen in the Epidermis and CD4 in the dermis
- Antigen-presenting cells in the skin, such as Langerhans cells

E. ENVIRONMENTAL FACTORS

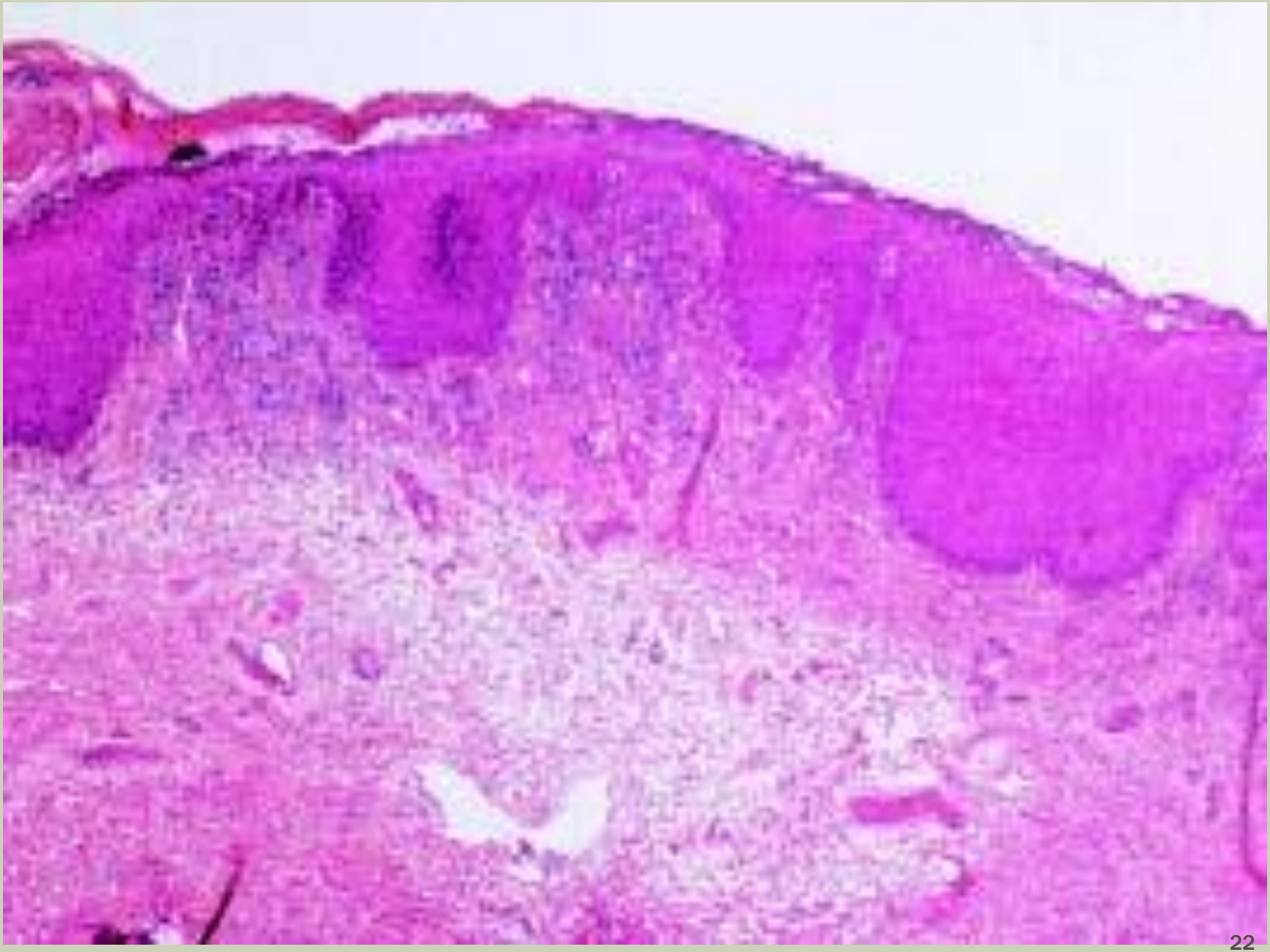
- Infection (streptococcal infection in the form of sore throat) which can cause guttate psoriasis
- Physical agents (e.g., stress, alcoholism, smoking)
- Koebner phenomenon (refers to skin lesions appearing on lines of trauma) مهمه ولكنها علامه غير مميزه للمرض
- Drugs
- Lithium
- anti-malarials: chloroquine
- NSAIDs
- Beta-blocker


In Lymphnode
CD3
MHCI/IP
TCR
CD4/CD8
APC
T-cell
ICAM-1
LFA-1
CD86
CTLA-4
CD80
CD28
LFA-3
CD2
CD40
CD40L
epidermis
dermis
antigen-presenting cell
antigen
cytokines
E&P Selectins
VCAM
ICAM
CLA
mature activated T-cell
LFA-1
VLA-4
blood vessel

مهمة

HISTOLOGY

1. Parakeratosis: nuclei retained in the stratum cornium → due to repeated cells division
2. Irregular thickening of the epidermis over the rete ridges but thinning over dermal papillae
3. Epidermal polymorphonuclear leukocyte infiltrates (munro abscesses)
4. There are epedermotrippers : – خلايا التهاب تدخل في النسيج الجلدي تكون جزء منه
5. Dilated capillary loops in the dermal papillae
6. T-lymph infiltrate in the upper dermis
7. No granular layer



TYPES & SITES

Types

1. Plaque: Most common form of the disease
2. Guttate: Appears as small red spots on the skin
3. Inverse: Occurs in armpits, groin and skin folds
4. Pustular: Sterile small pustules, surrounded by red skin
5. Erythrodermic: Intense redness over large areas
6. Psoriatic arthritis

Sites

- Can occur at any site:
  - Scalp psoriasis
  - Genital psoriasis
  - Around eyes, ears, mouth and nose
  - On the hands and feet
  - Psoriasis of the nails

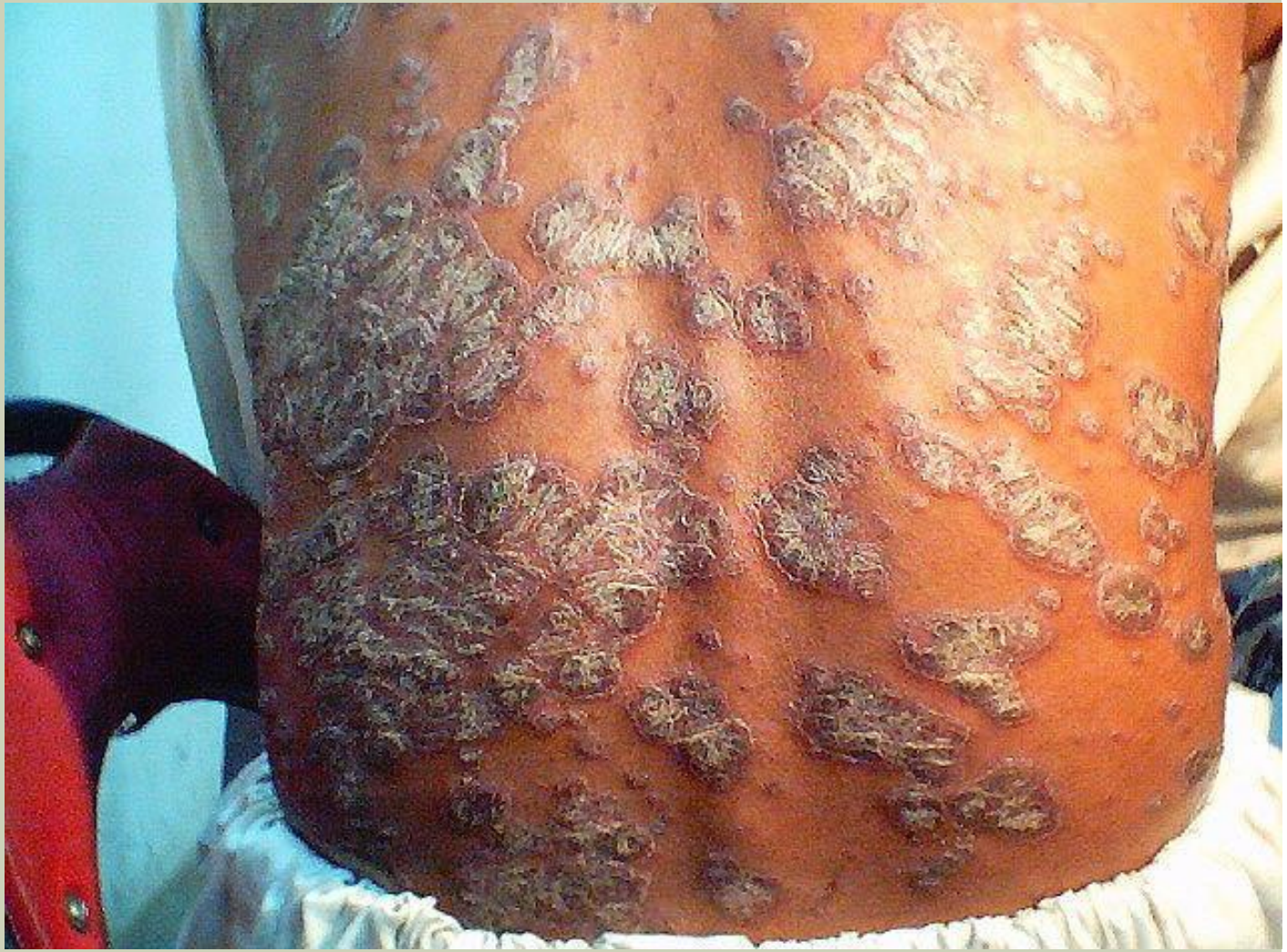
كلها ستفصل لاحقاً

- The most common
- Characterized by round-to-oval red plaques distributed over **extensor** body surfaces (usually knees, elbows) and the scalp
- Up to 10-20% of patients with plaque psoriasis may evolve into more severe disease, such as pustular or erythrodermic psoriasis
- Pin point bleeding occurs when you remove the scales: Auspitz' sign

1. PLAQUE PSORIASIS (PSORIASIS VULGARIS)

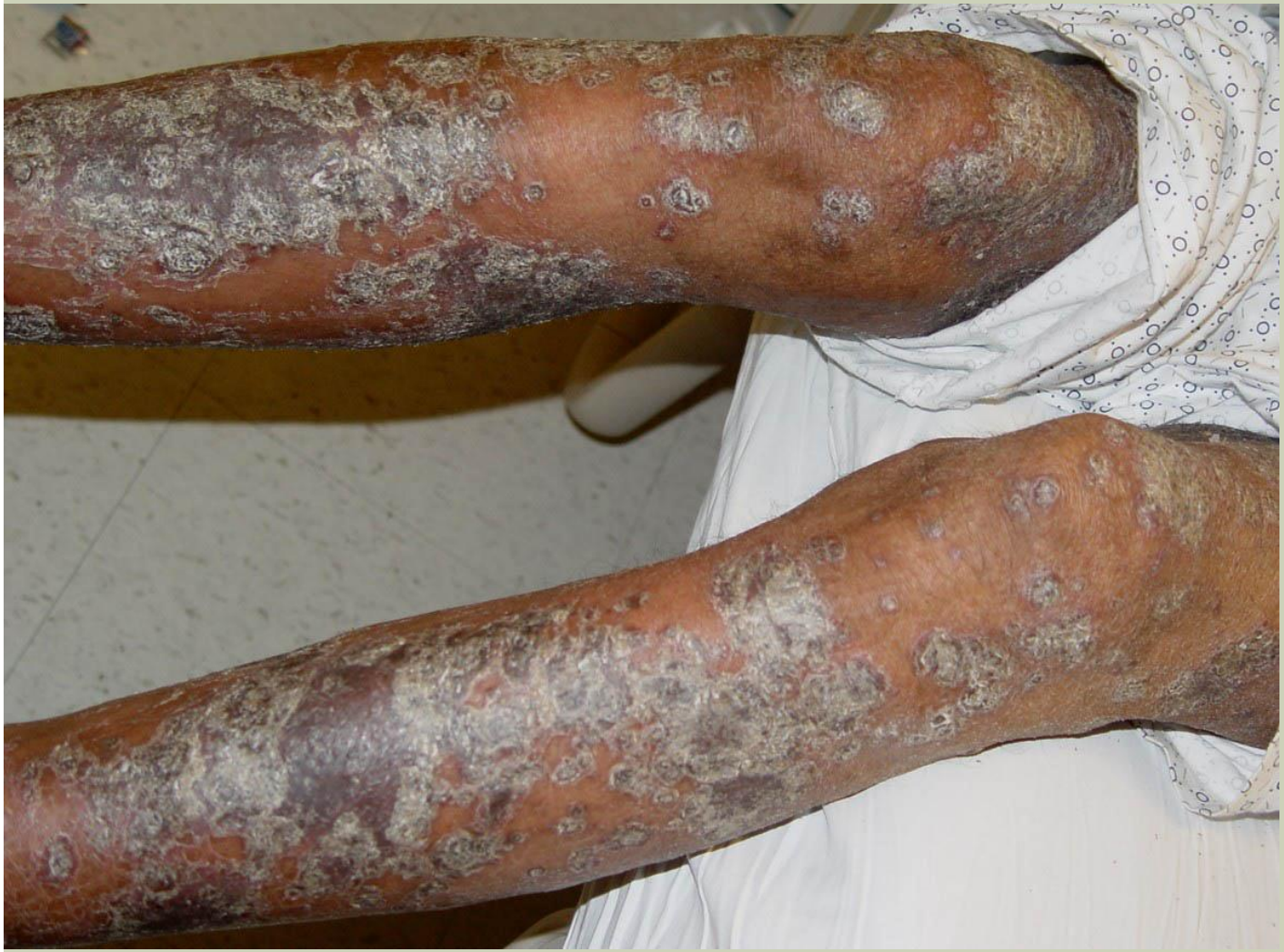
The severity depends on:

1. The coverage surface (%)
2. If the disease limits the pt. (function limitation)
3. Type: pustular or not
4. social factors



1. PLAQUE PSORIASIS (PSORIASIS VULGARIS)

Extensive chronic psoriasis



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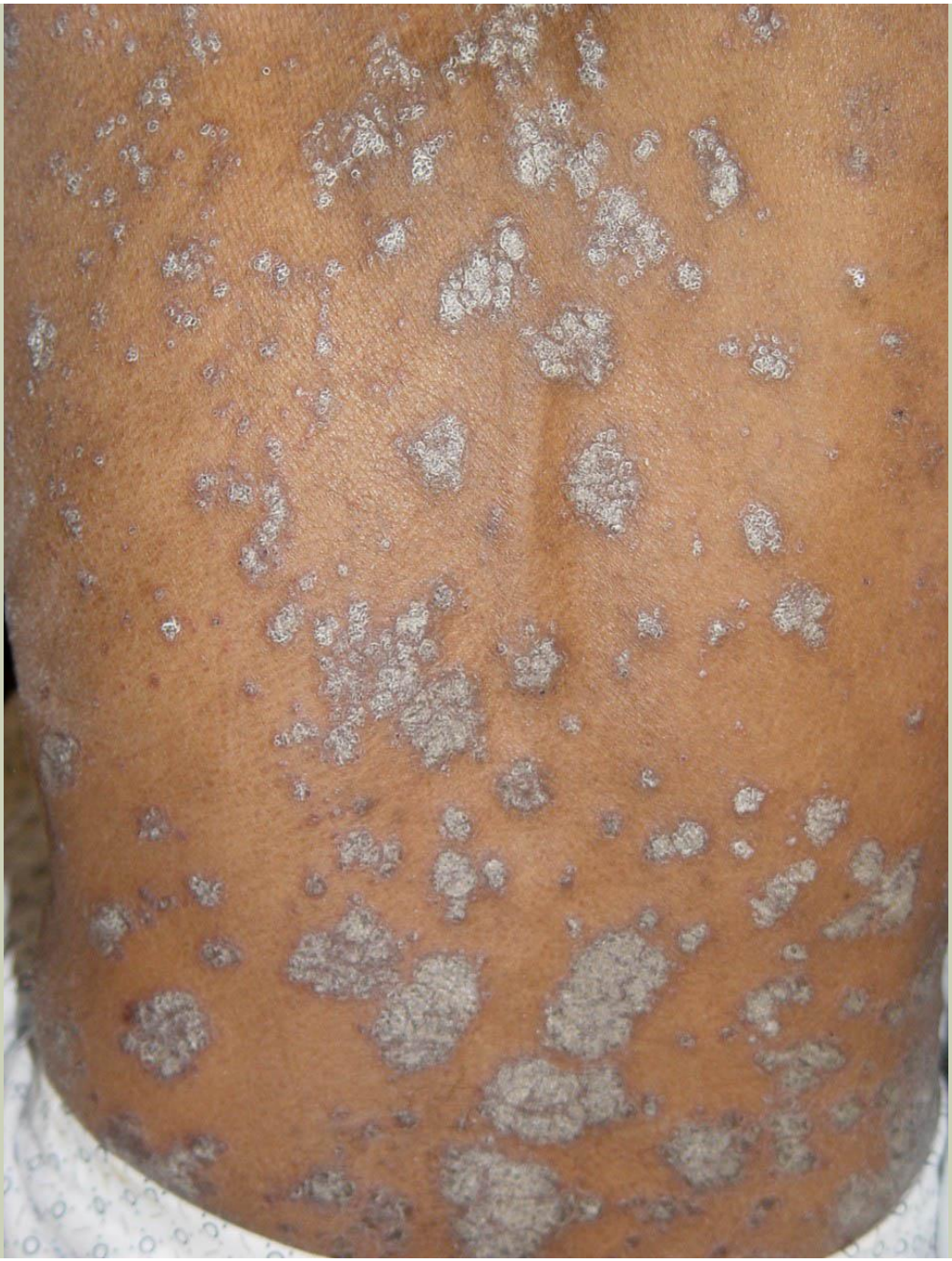


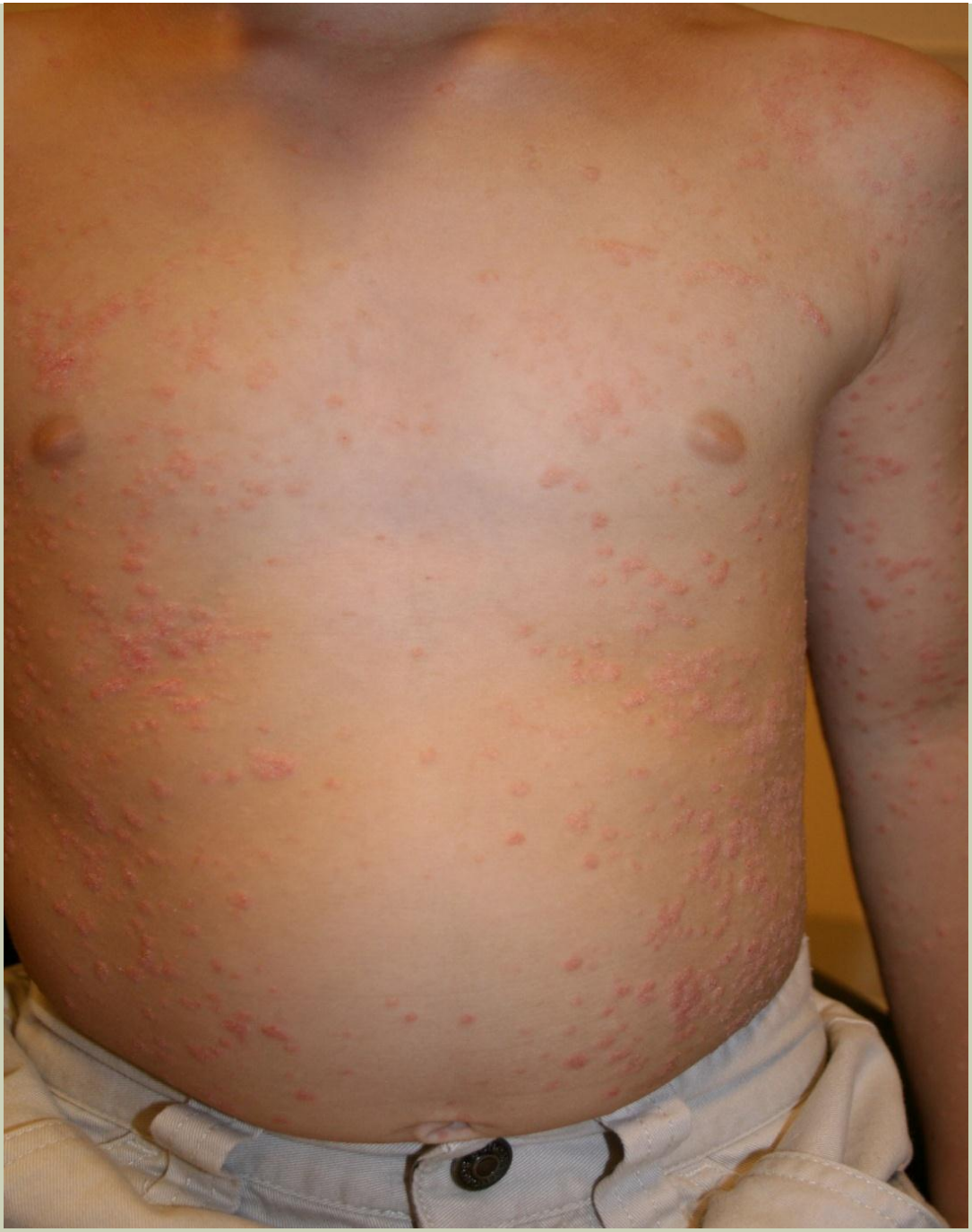
1. PLAQUE PSORIASIS (PSORIASIS VULGARIS)

Extensive chronic psoriasis

- Small, drop like, 1-10 mm in diameter, salmon- pink papules, usually with a fine scale
- Younger than 30 years مهمه
- Upper respiratory infection secondary to group A beta-hemolytic streptococci
- On the trunk and the proximal extremities
- Resolution within few months
- All affected patients carry the HLA-CW6 antigen

2. PSORIASIS GUTTATE

فرقها عن النوع اللي قبل - محل اسئله



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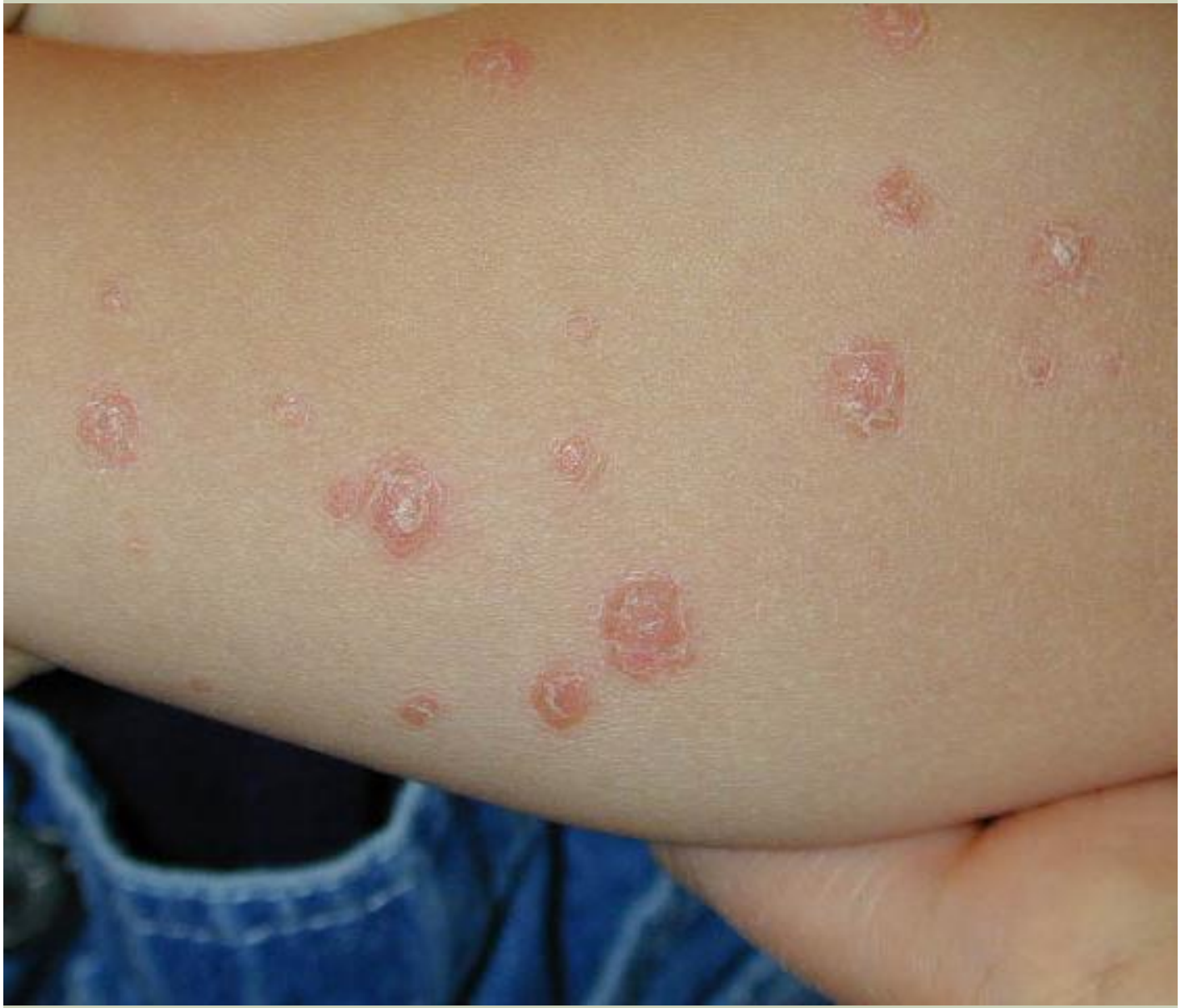
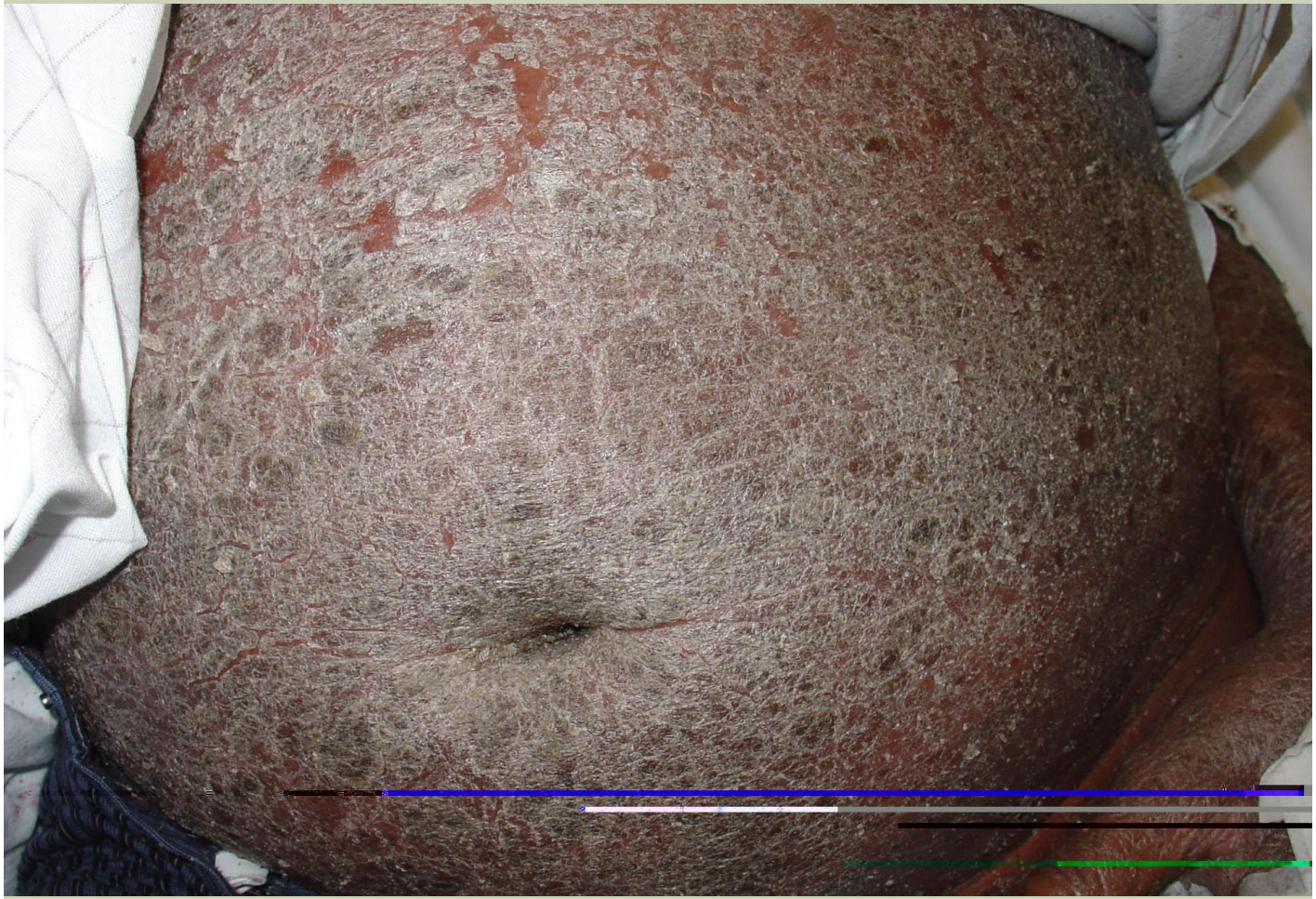


2. PSORIASIS GUTTATE

- Scaly erythematous lesions, involving 90% or more of the cutaneous surface
- Extensive erythema
- Hair may shed; nails may become ridged and thickened
- Few typical psoriatic plaques
- Unwell, fever, leukocytosis
- Excessive of body heat and hypothermia
- Increase cut blood flow
- Increase per-cutaneous loss of water, protein and iron > loss of fluid can lead to high output heart failure
- Increase per-cutaneous permeability

3. ERYTHRO-DERMIC PSORIASIS

In this type the inflammation process finish all of the body's Protein and Iron → So it always associated with (Anemia and Hypothermia) مهمه جدا



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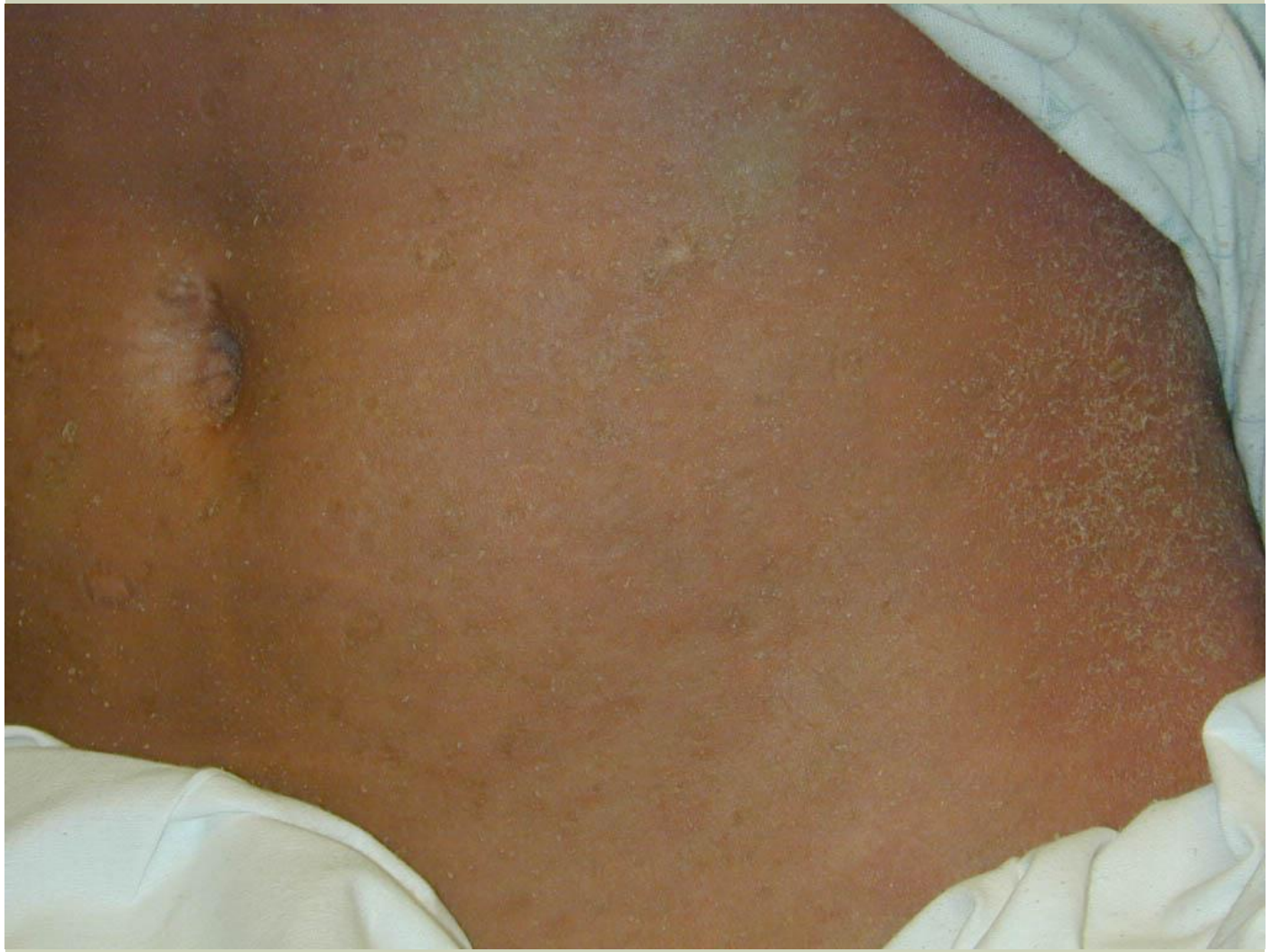


3. ERYTHRO-DERMIC PSORIASIS

- Uncommon form of psoriasis
- There are sterile pustules on an erythematous background مهمه
- Psoriasis vulgaris may be present before, during, or after
- Pustular psoriasis may be classified into several **types**
  - Generalized type (von Zumbasch)
    - Generalized erythema studded with interfolecular pustules
    - Fever, tachypneic, tachycardia due to fluid imbalance which can cause high output heart failure
    - Absolute lymphopenia with polymorph nuclear leukocytosis up to 40,000/µl
  - Localized:
    - Chronic variant on the palms and soles

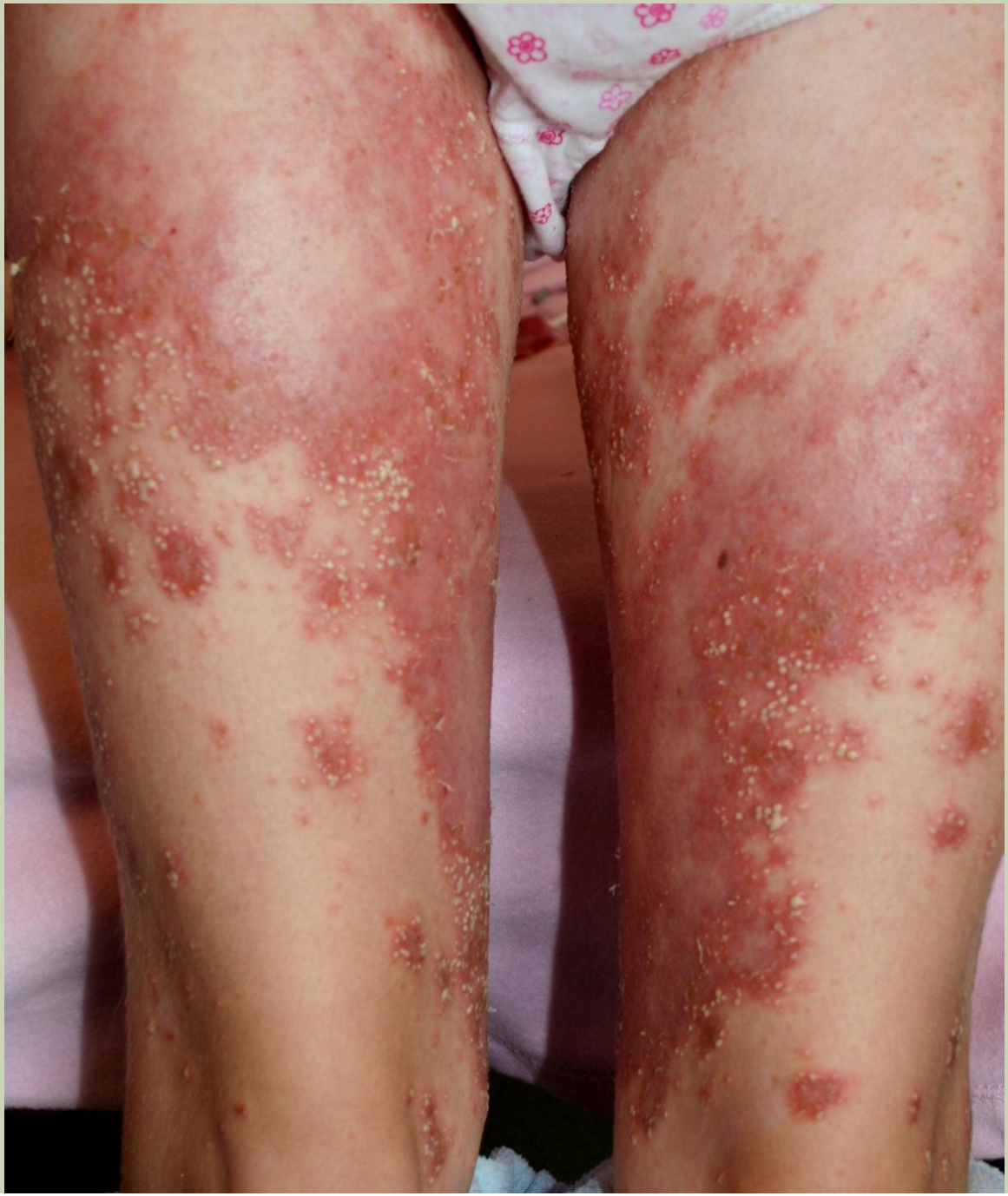
4. PUSTULAR PSORIASIS

Types are important

مهمة

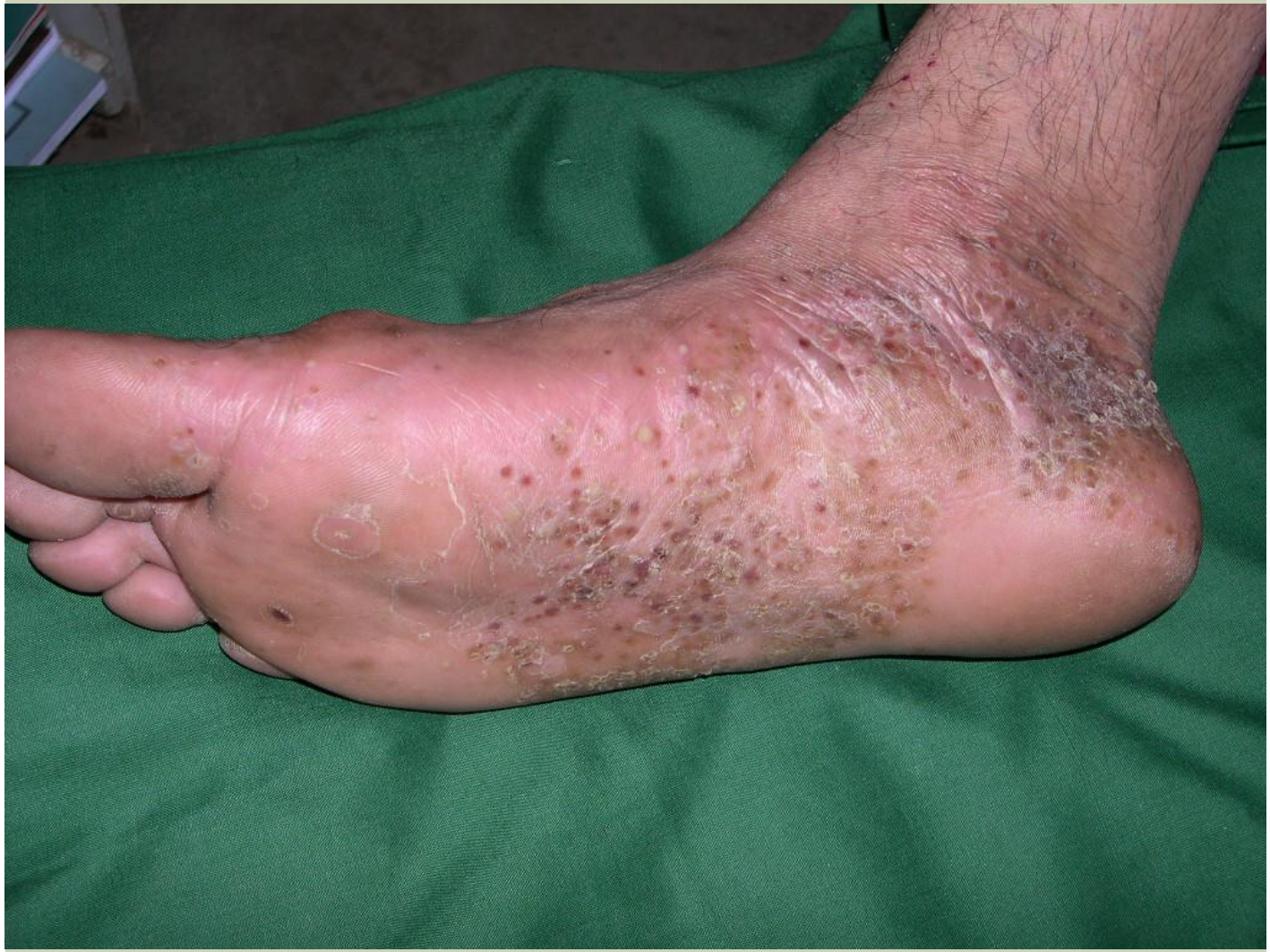
CAUSES OF PUSTULAR PSORIASIS

1. Withdrawal of systemic steroids
2. Drugs, including salicylates,, lithium, phenylbutazone,, hydroxychloroquine,, interferon
3. Strong, irritating topicals, including tar, anthralin, steroids under occlusion, and zinc pyrithione in shampoo
4. Infections
5. Sunlight or phototherapy
6. Cholestatic jaundice
7. Hypocalcemia
8. Idiopathic in many patients

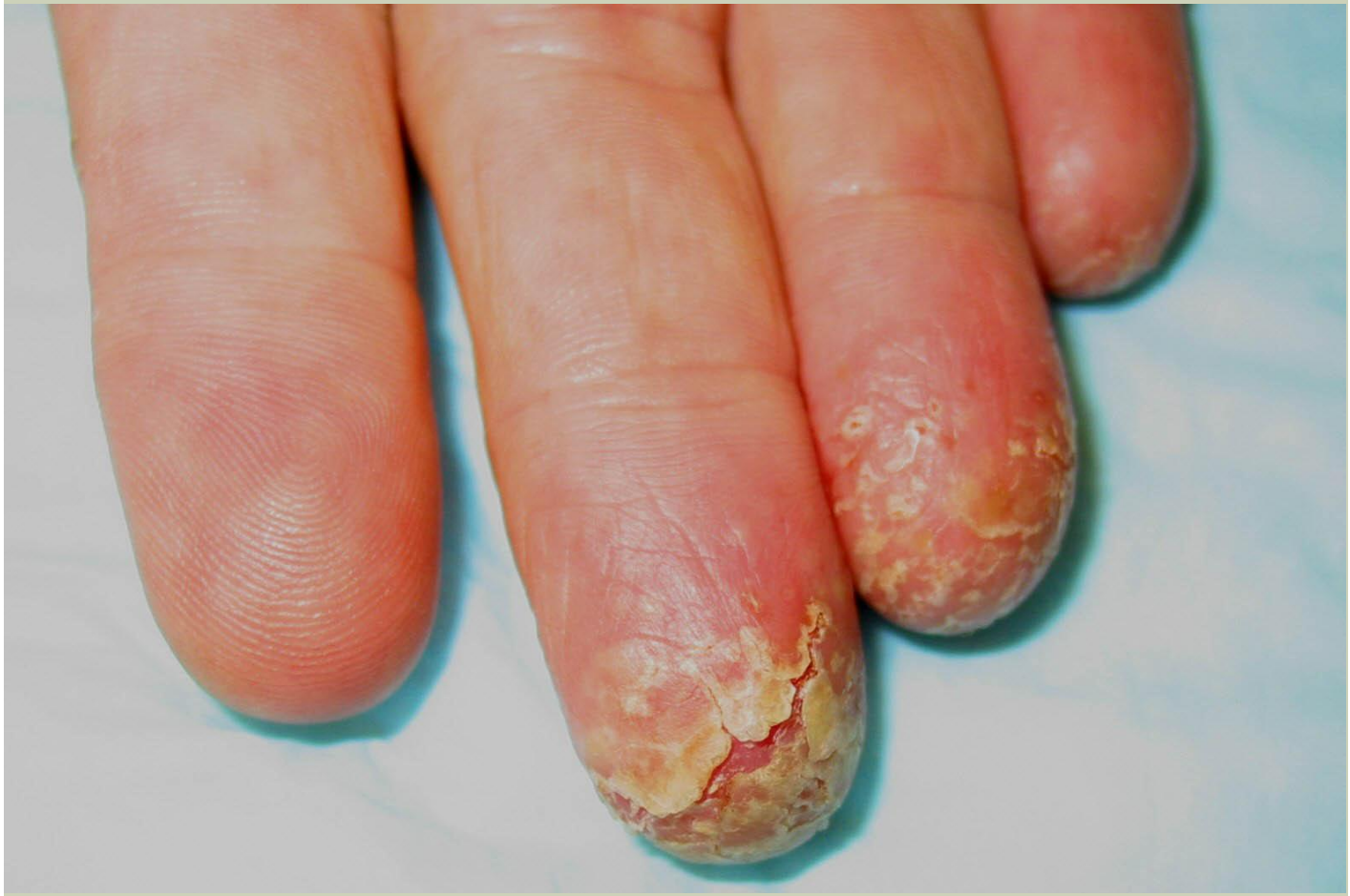


4. PUSTULAR PSORIASIS

It show pustule – covering the whole lesion and **IT DOES NOT SHOW SCALES** – مهمه علامه مميزه لهذا النوع



4. PUSTULAR PSORIASIS

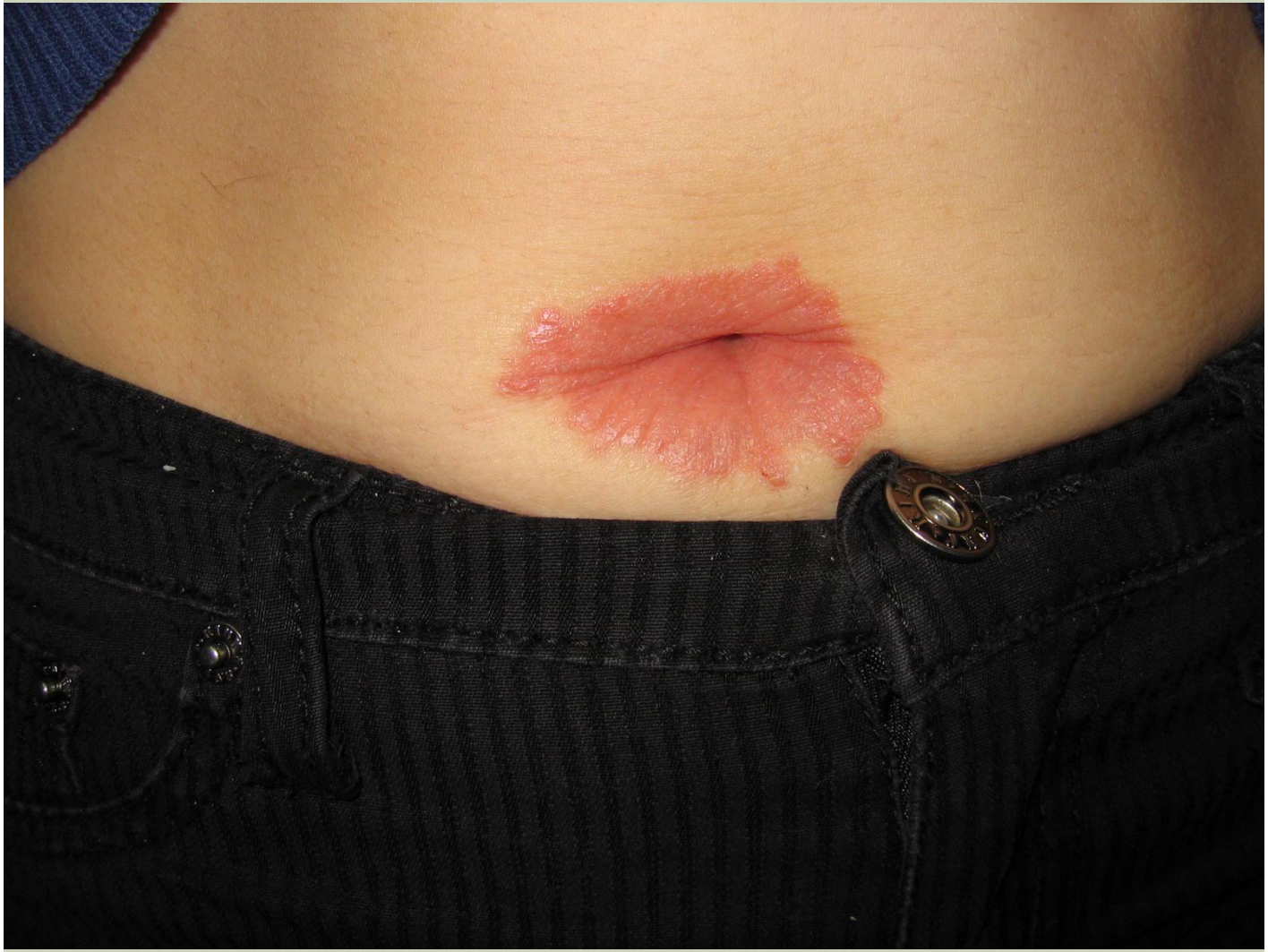


4. PUSTULAR PSORIASIS

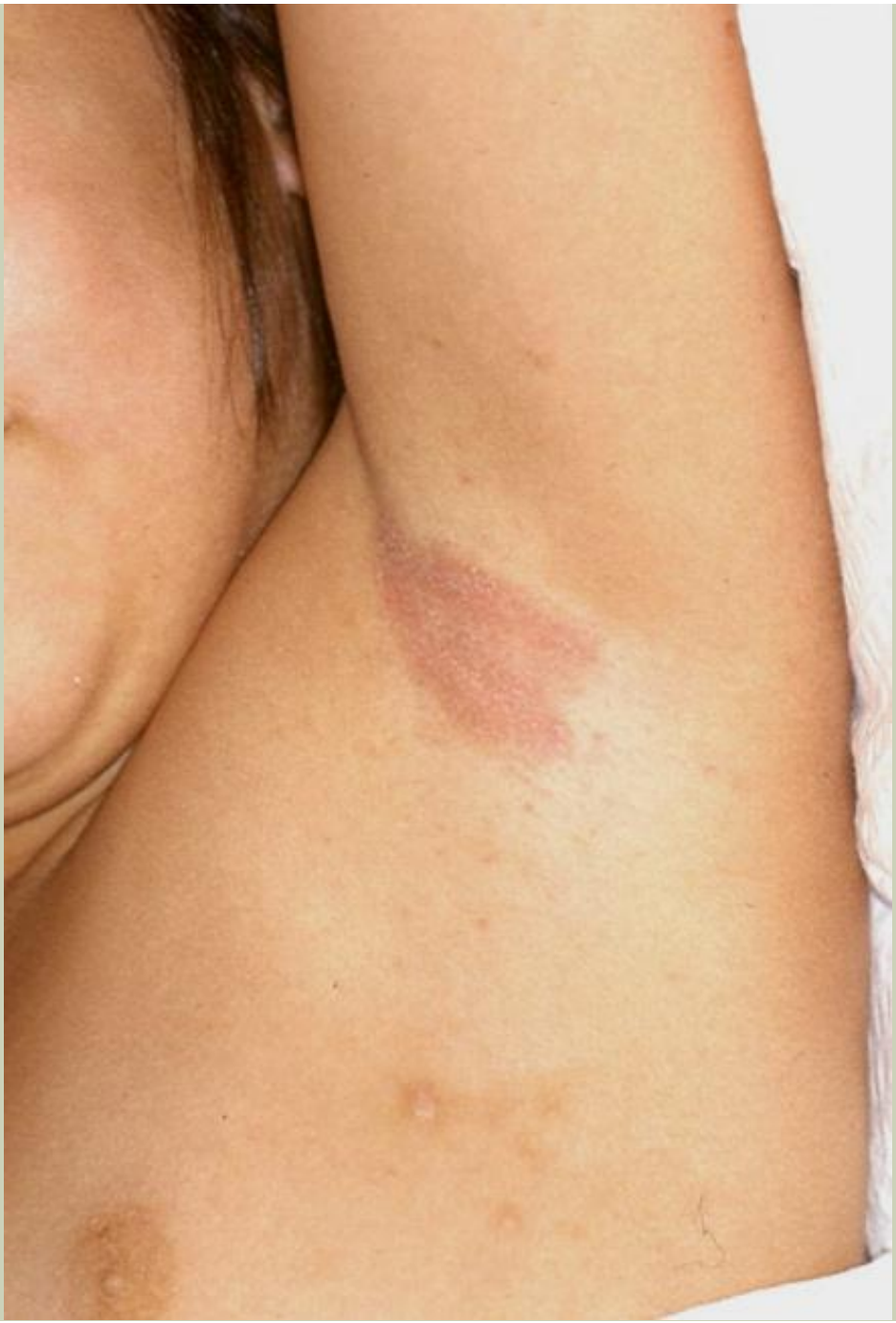
In Management of this type: Do Not Give Antibiotics

5. PSORIASIS INVERSUS (SEBO-PSORIASIS)

- Over body folds (Wet areas) → So it do not show Scales also → Always misdiagnosed
- The erythema and scales are very similar to that seen in seborrhoeic dermatitis
- Can be hard to treat as it is easily irritated by topical tar and dithranol



5. PSORIASIS INVERSUS (SEBO-PSORIASIS)



5. PSORIASIS INVERSUS (SEBO-PSORIASIS)

6. PSORIATIC ARTHRITIS

- Psoriatic arthritis is a chronic inflammatory arthritis that is commonly associated with psoriasis
- 5%of patients with psoriasis develop psoriatic arthritis
- Most commonly a seronegative oligoarthritis
- Asymmetric oligoarthritis (the most common) occurs in as many as 70% of patients with psoriatic arthritis
- DIP joint involvement occurs in approximately 5-10 of patients with psoriatic arthritis
- Arthritis mutilans (the most serious) is a rare form of psoriatic arthritis occurring in 5% of patients with psoriatic arthritis
- Spondylitis occurs in about 5% of patients with psoriatic arthritis and is often asymptomatic
- A higher incidence of arthritis occurs in patients with psoriatic nail changes

7. PSORIATIC NAIL

- Occurs in 10-55% of all patients with psoriasis
- Less than 5% of psoriatic nail disease cases occur in patients without other cutaneous findings
- Nail changes are seen in 53-86% of patients with psoriatic arthritis
- You can see:
  - Oil drop or salmon patch/nail bed Pitting
  - Subungual hyperkeratosis
  - Onycholysis
  - Beau lines : longitudinal groove of the nails → it is Not Specific because it could occur in many other chronic disease

DIFFERENTIAL DIAGNOSIS

"The DDx depends on the findings, and each type has its own DDx."

- Bowes Disease
- Cutaneous T-Cell Lymphoma
- Drug Eruptions
- Erythema Annulare Centrifugum
- Extra-mammary Paget Disease
- Lichen Planus
- Lichen Simplex Chronicus
- Lupus Erythematosus, Discoid
- Lupus Erythematosus, Subacute Cutaneous
- Nummular Dermatitis
- Parapsoriasis
- Pityriasis Rosea
- Pityriasis Rubra Pilaris
- Seborrheic Dermatitis-
- Syphilis
- Tine Corporis

"You may need a biopsy to confirm the diagnosis."

Lab test: - Skin biopsy
- If the patient has joint pain → Rh factor & antinuclear antibody to exclude RA

TREATMENT

- What influences therapy choice?
  - Clinical type and severity of psoriasis (eg, mild vs moderate-to-severe), assessed by Psoriasis Area and Severity Index (PASI)
  - Response to previous treatment
  - Therapeutic options
  - Patient preference
- The "1-2-3" step approach is no longer generally accepted for disease more than mild in severity
  - Level 1: Topical agents—do not work
  - Level 2: "Phototherapy"—difficult; not always available
  - Level 3: Systemic therapy
- Risk in relation to benefit must be evaluated

>20%

Camisa C. *Cleve Clin J Med*. 2000;67:105-119.

A. TOPICAL AGENTS

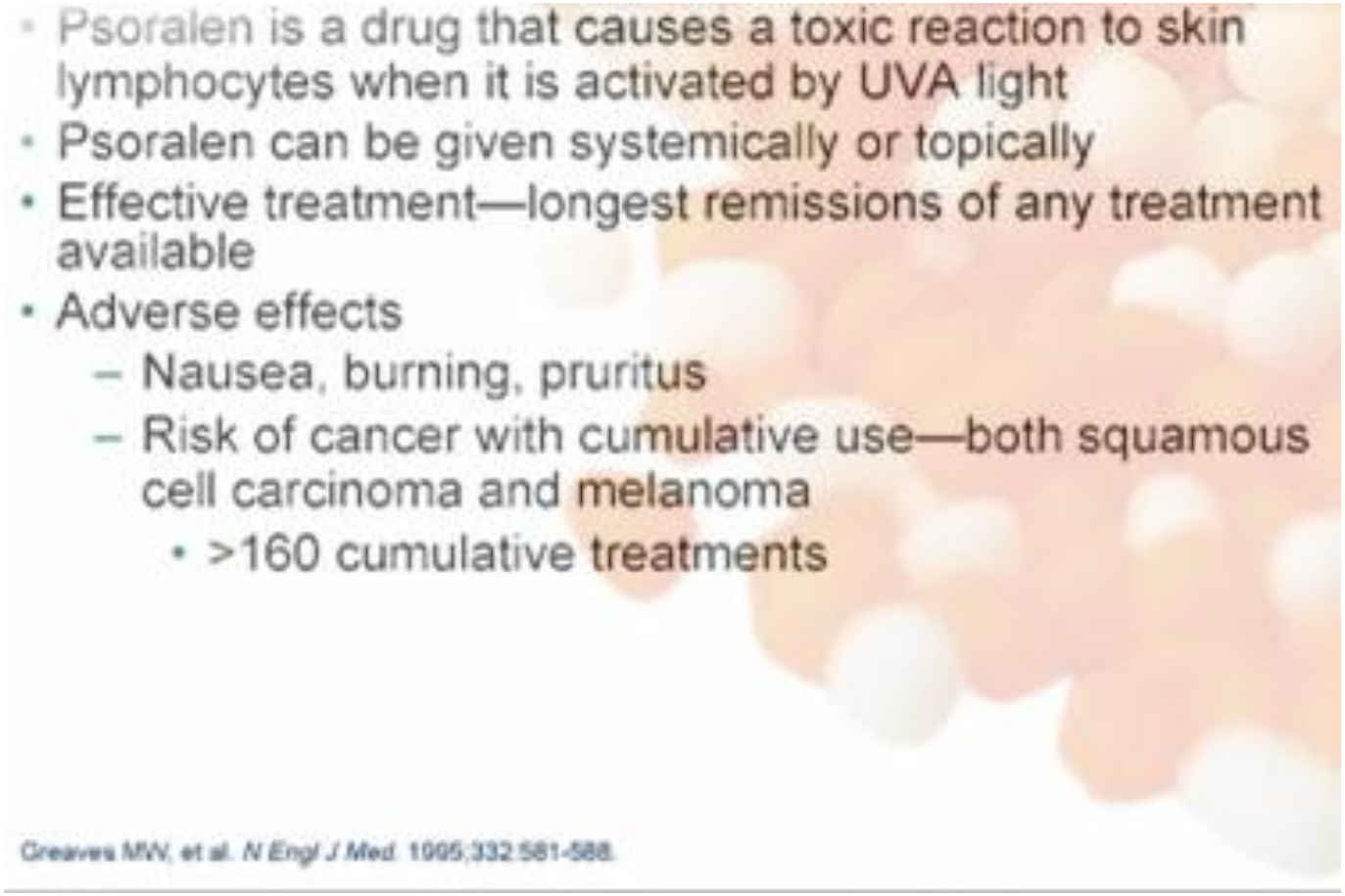
- Initial therapeutic choice for mild-to-moderate psoriasis
  - Emollients الدهون : مثل الفازلين
  - Keratolytics (salicylic acid, lactic acid, urea)
  - Coal tar
  - Anthralin
  - Vitamin D_3 analogues (calcipotriene)
  - Corticosteroids
  - Retinoids (tazarotene, acitretin)
- Compliance can be difficult due to amount of time required to apply topicals 2 to 4 times/day

Camisa C. *Cleve Clin J Med*. 2000;67:105-119.

B. PHOTO-THERAPY

- Used to treat moderate-to-severe psoriasis
- Phototherapy causes death of T cells in the skin
  - Natural sunlight
  - Ultraviolet (UV) B light
  - UVB light + coal tar (Goeckerman treatment)
    - Best therapeutic index for moderate-to-severe disease
  - UVB light + anthralin + coal tar (Ingram regimen)
  - Usually 3 treatments/week for 2 to 3 months is needed
  - Accessibility to a light box facility and compliance necessary

Camisa C. *Cleve Clin J Med.* 2000;67:105-119.



C. PUVA

UVA light with psoralen

D. METHOTREXATE

- Folic acid metabolite
  - Blocks deoxyribonucleic acid synthesis, inhibits cell proliferation
- Dose
  - Start at about 15 mg/week; maximum 30 mg/week
  - Can also be given intramuscularly
- Adverse effects مهم
  - Headache, nausea, bone marrow suppression
  - Cumulative dose predictive of liver toxicity
    - Prospectively identify risk factors for liver disease
    - Guidelines recommend liver biopsy after 1.5 g مهم
    - Teratogenic in men and women

Greaves MW, et al. *N Engl J Med*. 1995;332:581-588.

- Frequently used in combination with topical agents, systemic therapies, and UV light
- Less effective as monotherapy for plaque psoriasis
- Plaque psoriasis dose
  - Start at 10 to 25 mg/day
- Adverse effects (fewest dose-related adverse effects)
  - Peeling/dry skin, alopecia, muscle pain
  - Lipid abnormalities
- Teratogenic: avoid pregnancy

Greaves MW, et al. *N Engl J Med*. 1995;332:581-588.

E. ACITRETIN

Oral retinoid

F. CYCLOSPORINE

- Reserved for severe, recalcitrant disease
- Inhibits the proliferation of activated T cells
- Dose: 4 mg/kg/day, not to exceed 5 mg/kg/day
  - Tapering slowly may improve remission
- Use not recommended for >1 year
  - Renal toxicity
- Patients relapse 2 to 4 months after discontinuing
- Adverse effects
  - Immunosuppression: infections, possible malignancy
  - Hirsutism, gingival hyperplasia, muscle pain, infection
  - Serious: hypertension, renal failure

Lebwohl M, et al. *J Am Acad Dermatol*. 1998;39:464-475.

Anti TNF :

- ***Adalimumab (Humira)***: (Subcutaneous)
- ***Infliximab (Remicade)***: (By IV)
- ***Ustekinumab (Stelara)***: (Subcutaneous)

BIOLOGIC THERAPIES

Currently approved for the treatment of psoriasis.

جيده وفعاله ولكن مشكلتها انها غاليه الثمن ومن الممكن ان تسبب انخفاض المناعه وبالتالي ظهور الاصابات الكامنه مثل السل الرئوي = مهمه

1. Alefacept:
   a. Is the first biologic agent approved by the FDA for the treatment of psoriasis
   b. It works by blocking T cell activation and proliferation by binding to CD2 receptors on T cells
   c. This stops the T cells from releasing cytokines, which is the primary cause of the inflammation
   d. 7.5 mg by intravenous injection or 15 mg by intramuscular injection once weekly for 12 weeks
   e. S/E: dizziness, cough, nausea, itching, muscle aches, chills, injection site pain, redness and swelling, and infections

2. Efalizumab (Raptiv) تم حظره؛ محذوف

a. Recombinant humanized igg1-kappa iso-type monoclonal antibody
b. Anti-cd11a antibody
c. Down-regulates (decreases) surface expression of cd11a by 75-85% at psoriasis doses
d. Initial dose: 0.7 mg/kg SC. Subsequent doses:
e. 1 mg/kg/week SC
f. S/E: Headache, chills, fever, nausea, vomiting, thrombocytopenia
    a. May increase infection risk

3. Etanercept (Enbril)

a. This molecule serves as an exogenous TNF receptor and prevents excess TNF from binding to cell-bound receptors
b. 50mg SC given twice weekly for 3 months, then 50 mg SC every week
c. Contraindications: sepsis, active infection, concurrent live vaccination
d. S/E:- injection site reactions (**most common**), upper respiratory tract infections

BIOLOGIC THERAPIES

Currently approved for the treatment of psoriasis.

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2. LICHENS PLANUS

الحزاز

BACKGROUND

- A pruritic, papular eruption characterized by its violaceous color; polygonal shape; and, sometimes, fine scale (whicham style)
- It is most commonly found on the **flexor** surfaces of the upper extremities, on the **genitalia**, and on the **mucous membranes**
- **Epidemiology**:
  - Approximately 1% of all new patients seen at health care clinics
  - Rare in children
  - F=M
  - No racial predispositions have been noted
  - LP can occur at any age but two thirds of patients are aged 30-60 years

PATHOPHYSIOLOGY

- The cause of LP is unknown
- LP may be a cell-mediated immune response of unknown origin
- LP may be found with other diseases of altered immunity like ulcerative colitis, alopecia areata, vitiligo, dermatomyositis
- An association is noted between LP and hepatitis C virus infection, chronic active hepatitis, and primary biliary cirrhosis
- Familial cases
- Drug may induce lichenoid reaction like مهمه جدا Thiazide, antimalarials, propranolol

CLINICAL FEATURES

- Most cases are **insidious**
- The **initial** lesion is usually located on the **flexor surface of the limbs**
- After a week or more → a generalized eruption develops with maximal spreading within 2-16 weeks
- **Pruritus** is common but varies in severity
- Oral lesions may be asymptomatic or have a burning sensation → So always examine the mucous membrane مهمه
- In >50% of patients with coetaneous disease, the lesions resolve within 6 months, and 85% of cases subside within 18 months

- The papules are violaceous, shiny, and polygonal; varying in size from 1 mm to >1 cm
- They can be discrete or arranged in groups of lines or circles
- Characteristic fine, white lines, called **Wickham striae**, are often found on the papules
- Oral lesions are classified as reticular, plaque-like, atrophic, papular, erosive, and bullous
- **Ulcerated oral lesions may have a higher incidence of malignant transformation** مهمه جدا – لذلك يجب فحص المريض بانتظام
- Genital involvement is common in men with cutaneous disease
- Vulvar involvement can range from reticulate papules to severe erosions

VARIATIONS

1. Hypertrophic LP:
   - These extremely pruritic lesions are most often found on the extensor surfaces of the lower extremities, especially around the ankles
2. Atrophic LP:
   - Is characterized by a few lesions, which are often the resolution of annular or hypertrophic lesions
3. Erosive LP
4. Follicular LP:
   - Keratotic papules that may coalesce into plaques
   - A scarring alopecia may result
5. Annular LP:
   - Annular lesions with an atrophic center can be found on the buccal mucosa and the male genitalia
6. Vesicular & Bullous LP:
   - Develop on the lower limbs or in the mouth from preexisting LP lesions
7. Actinic LP:
   - Africa, the middle east, and India
   - Mildly pruritic eruption
   - Characterized by nummular patches with a hypopigmented zone surrounding a hyperpigmented center
8. LP Pigmentosus:
   - Common in persons with darker-pigmented skin
   - Usually appears on face and neck

LP AND NAILS

- In 10% of patients
- Nail plate thinning causes longitudinal grooving and ridging
- Subungual hyperkeratosis, onycholysis
- Rarely, the matrix can be permanently destroyed with prominent pterygium formation
- twenty-nail dystrophy الاظافر تلتحم مع البطانه

MANAGEMENT

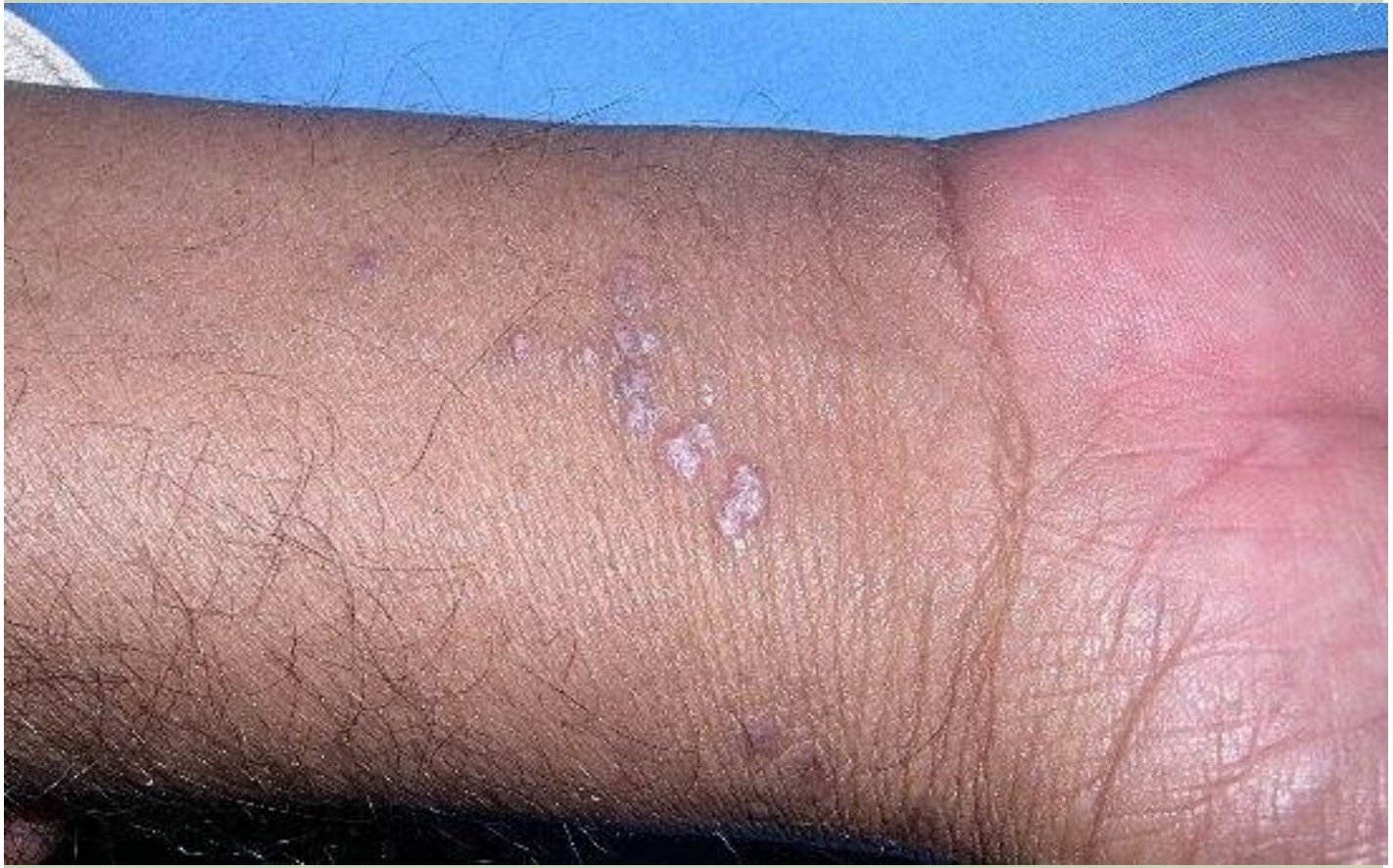
Differentials

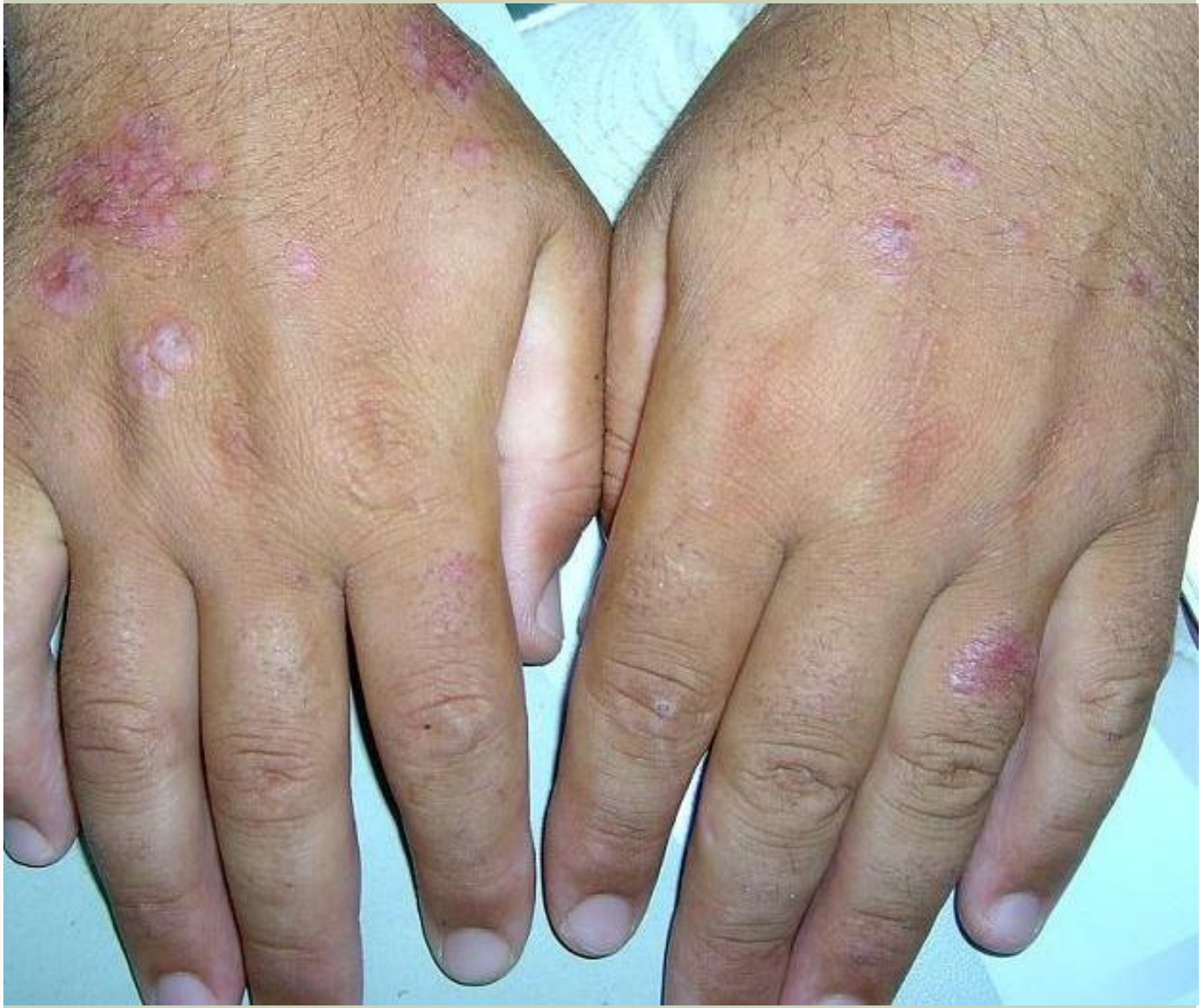
1. Graft Versus Host Disease
2. Lichen Nitidus
3. Lichen Simplex Chronicus
4. Pityriasis Rosea
5. Psoriasis, Guttate Psoriasis, Plaque
6. Syphilis
7. Tine Corporis

Treatment

- **SELF-LIMITED** disease that usually resolves within 8-12 months
- The most important thing is to stop the itch
  - **Anti-histamine**
  - **Topical steroids**, particularly class I or II ointments
  - **Systemic steroids** for symptom control and possibly more rapid resolution
  - **Oral acitretin**
  - **Photo-therapy**
  - Others

LICHENS PLANUS





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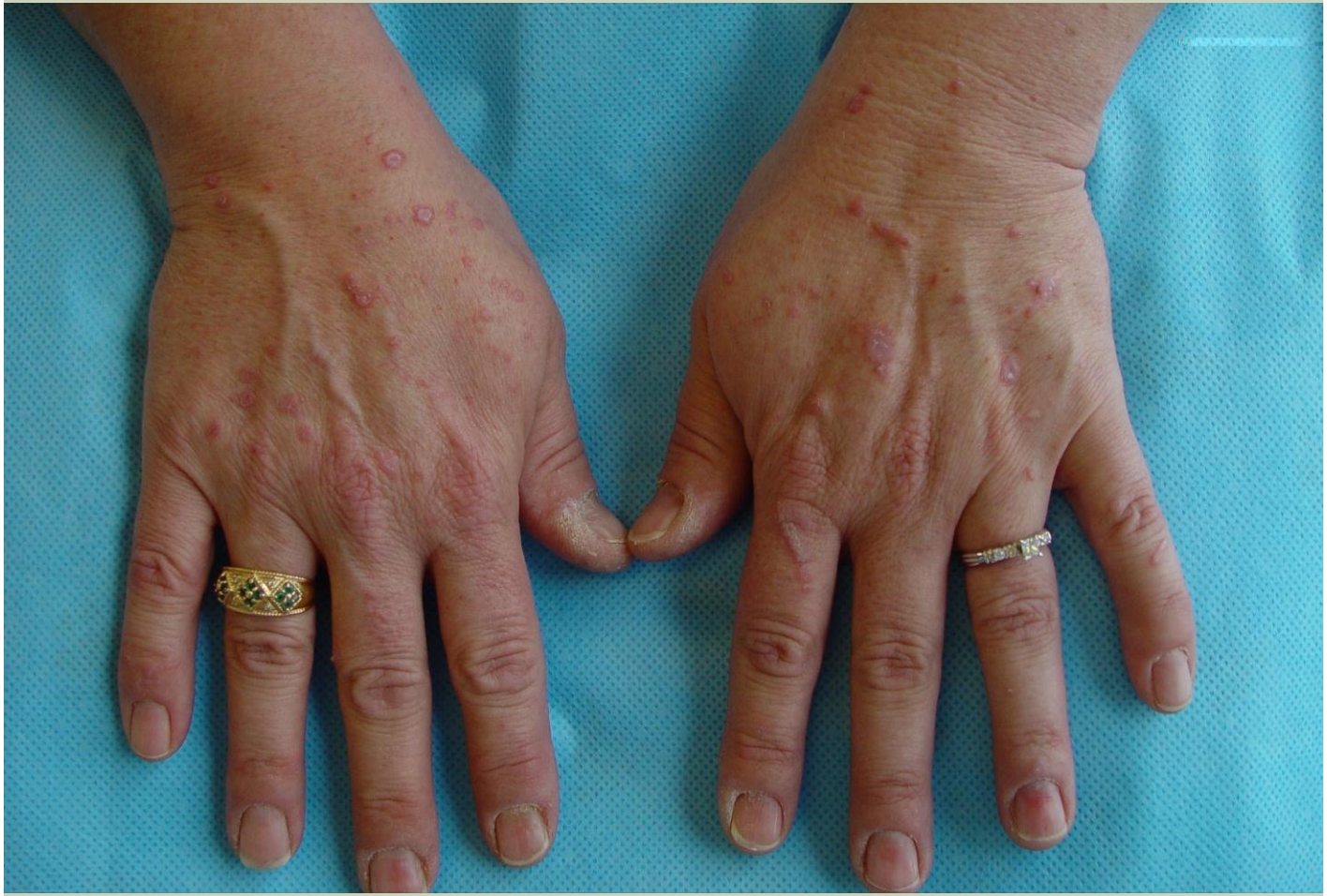

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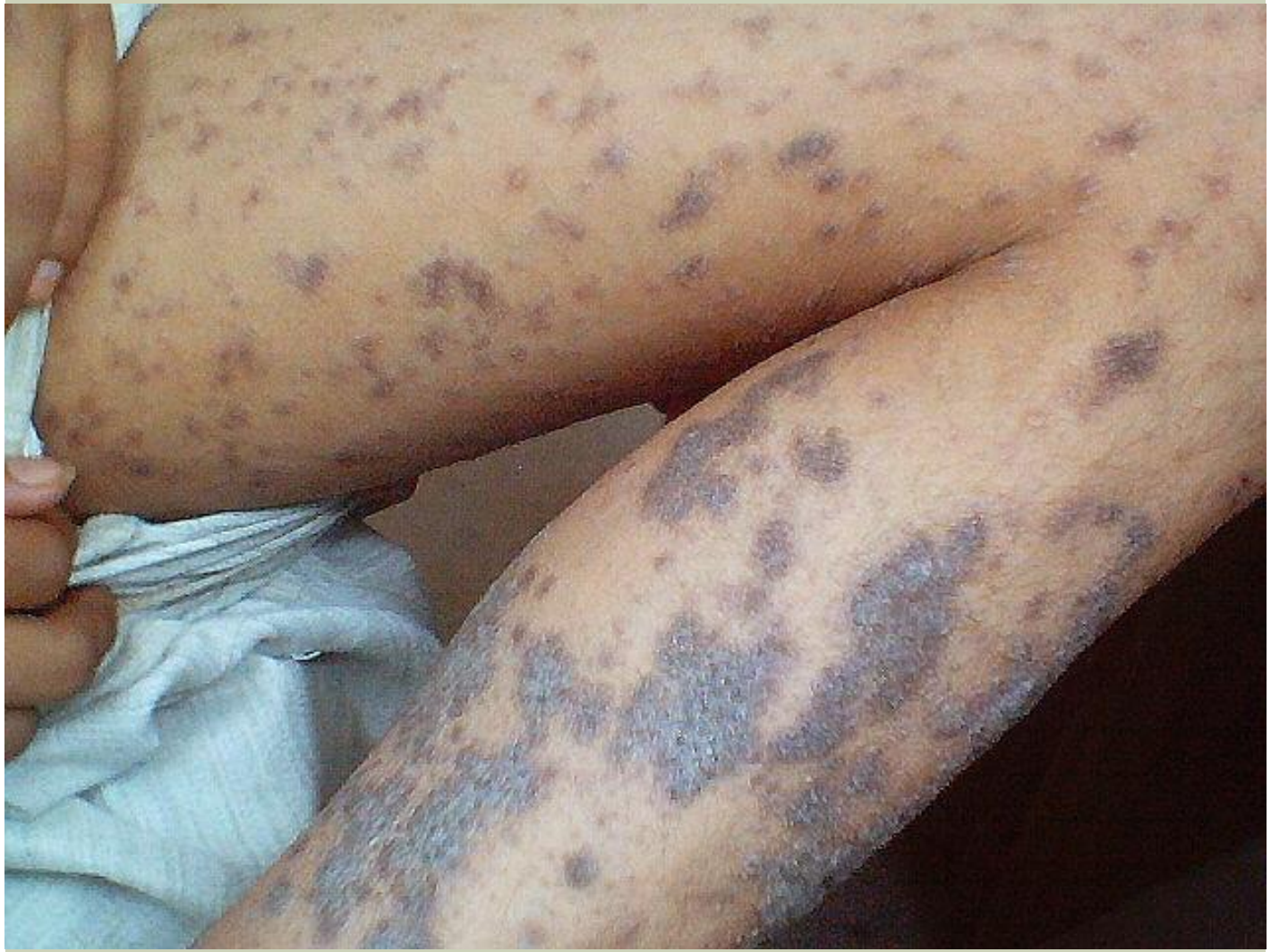

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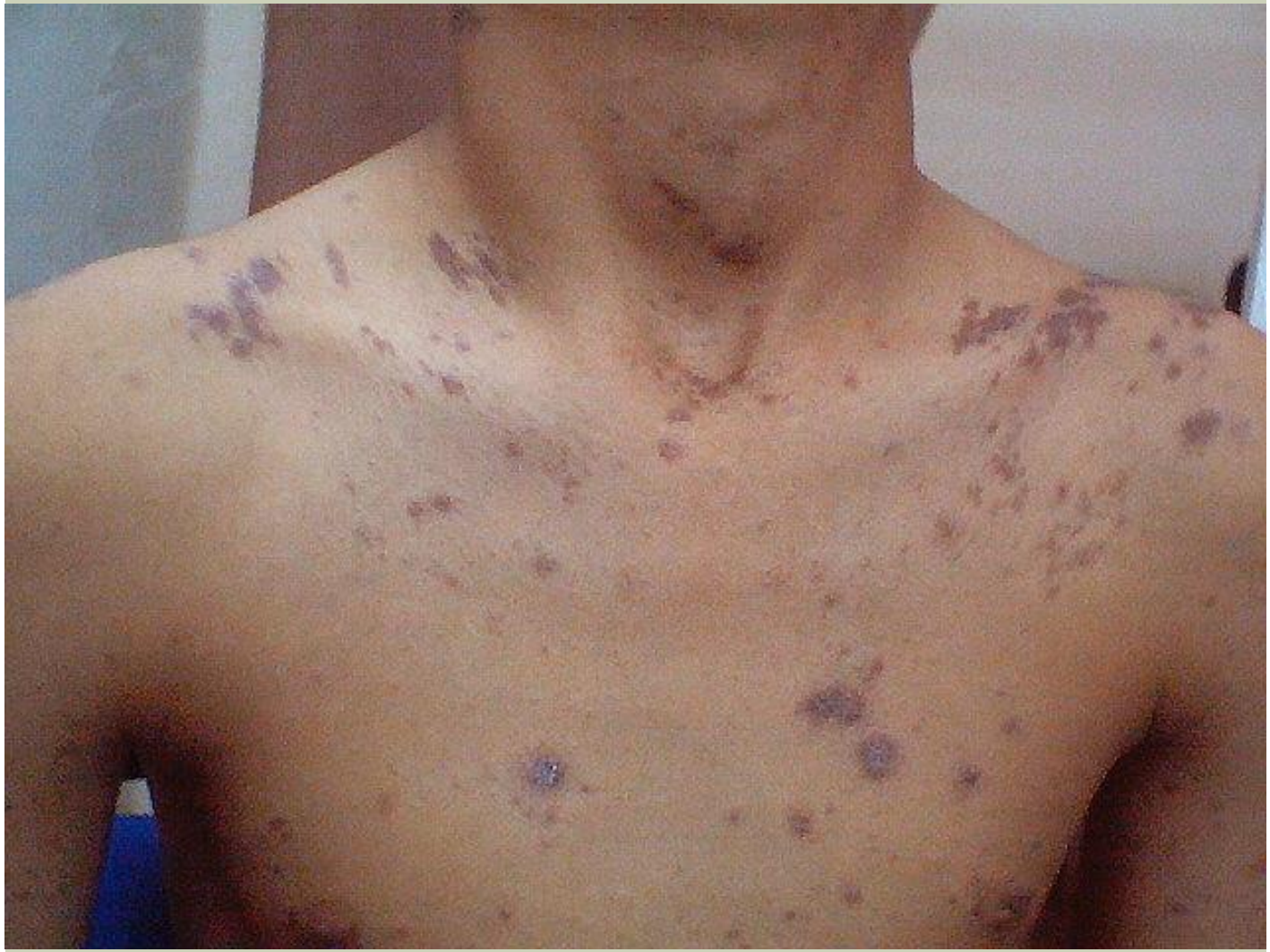

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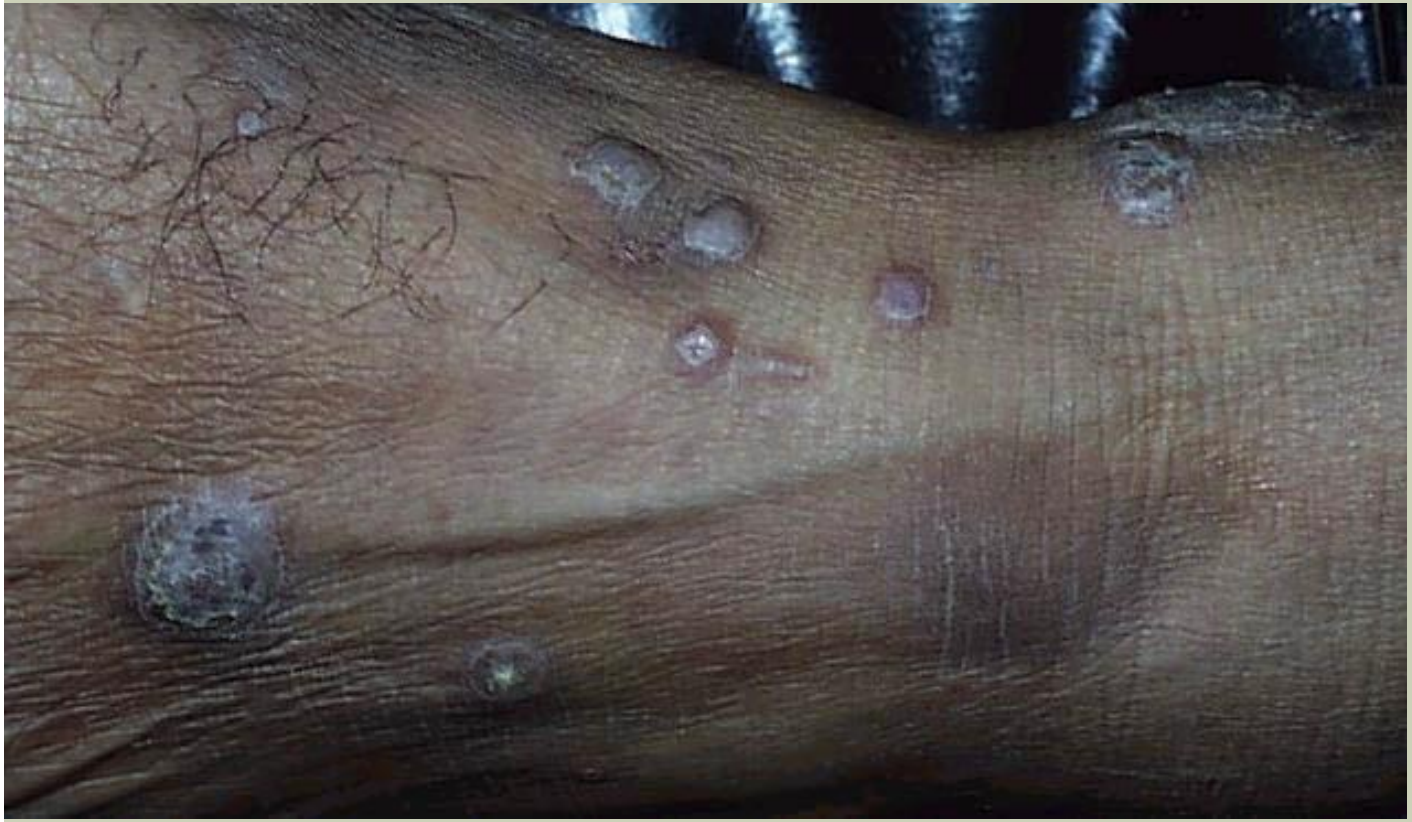

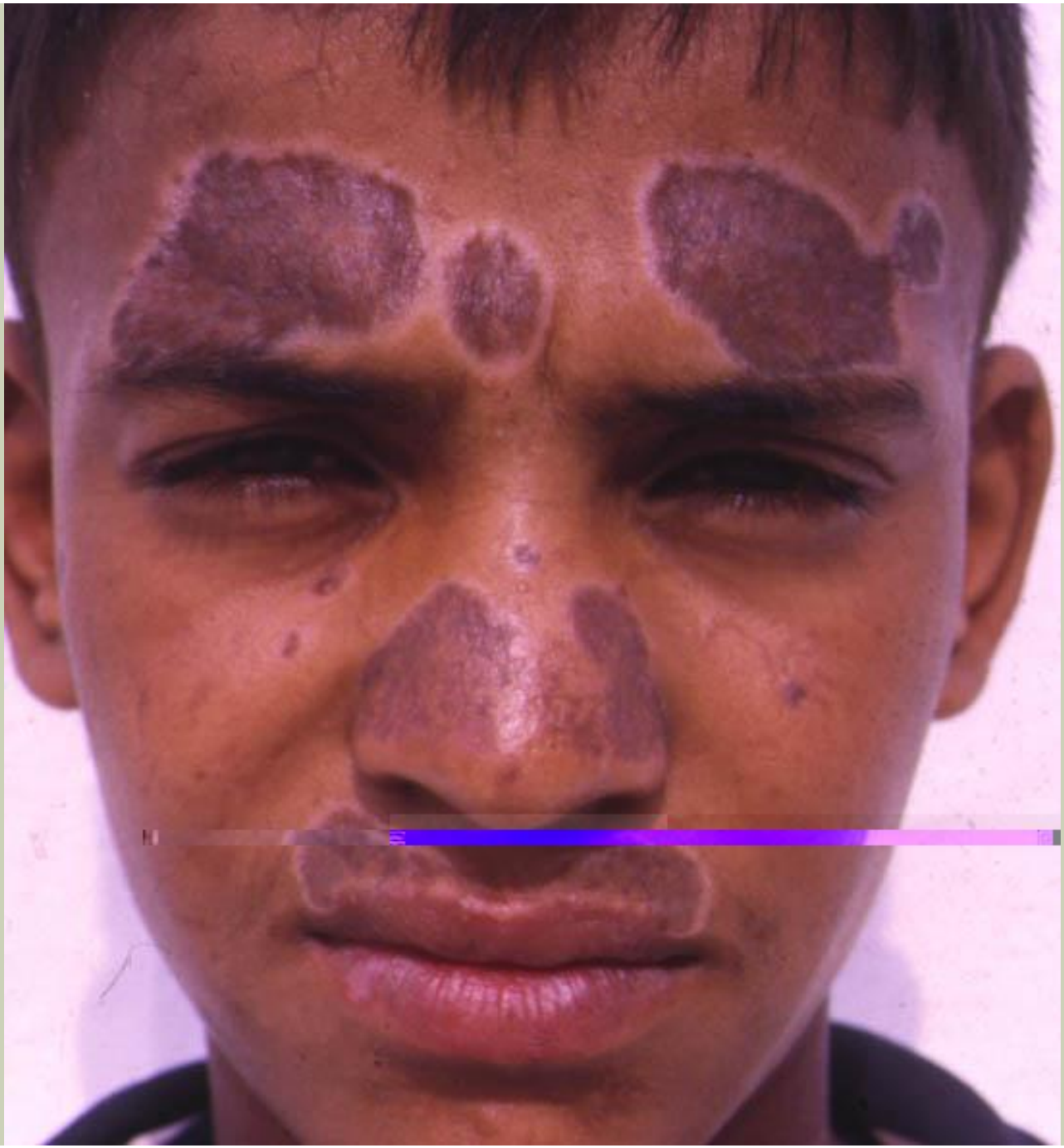

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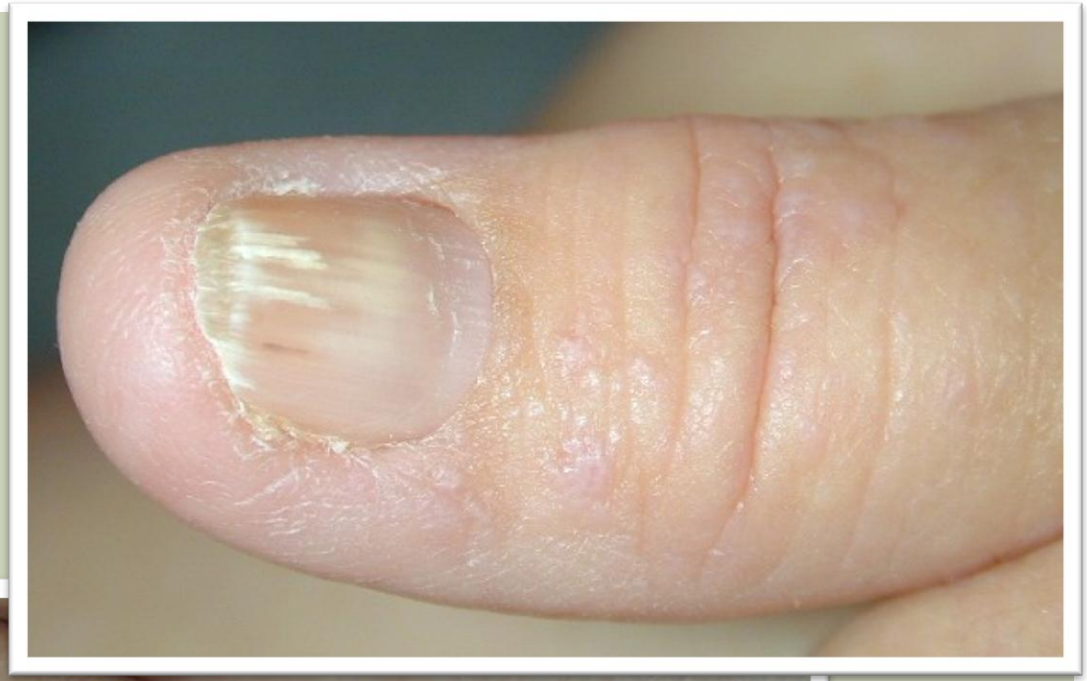

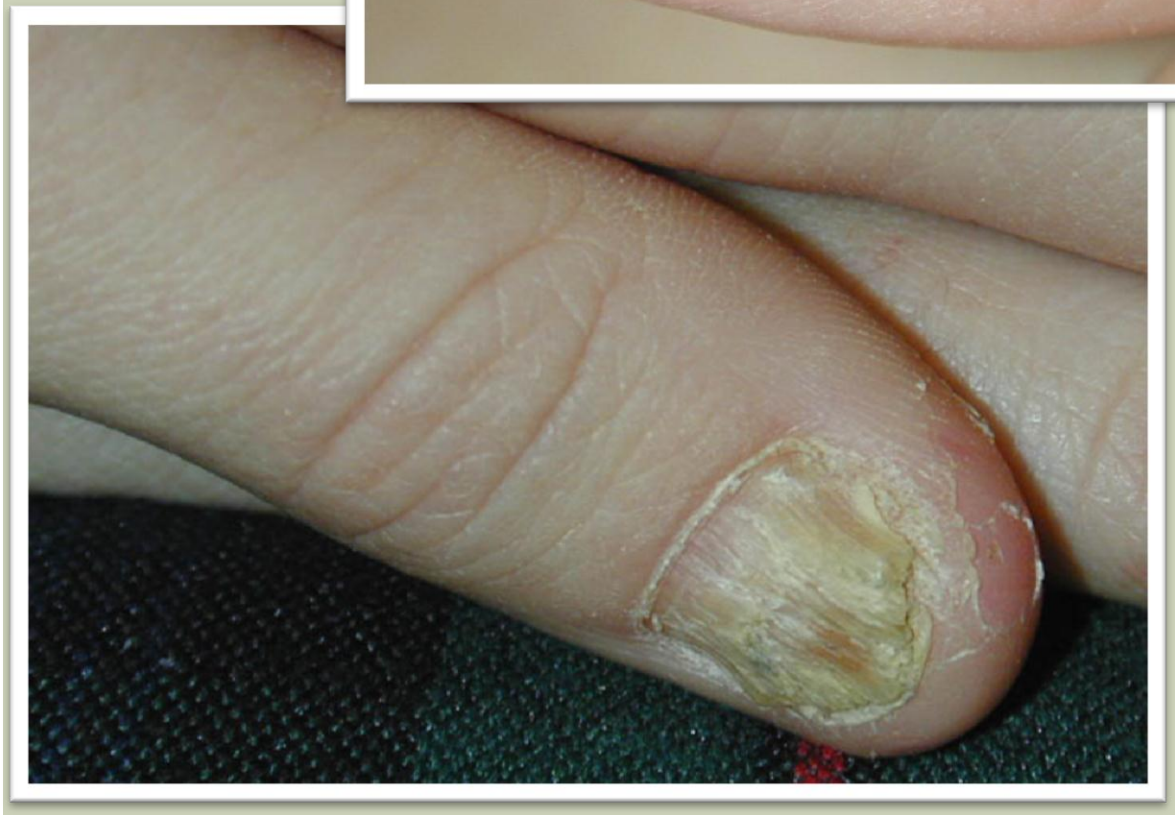

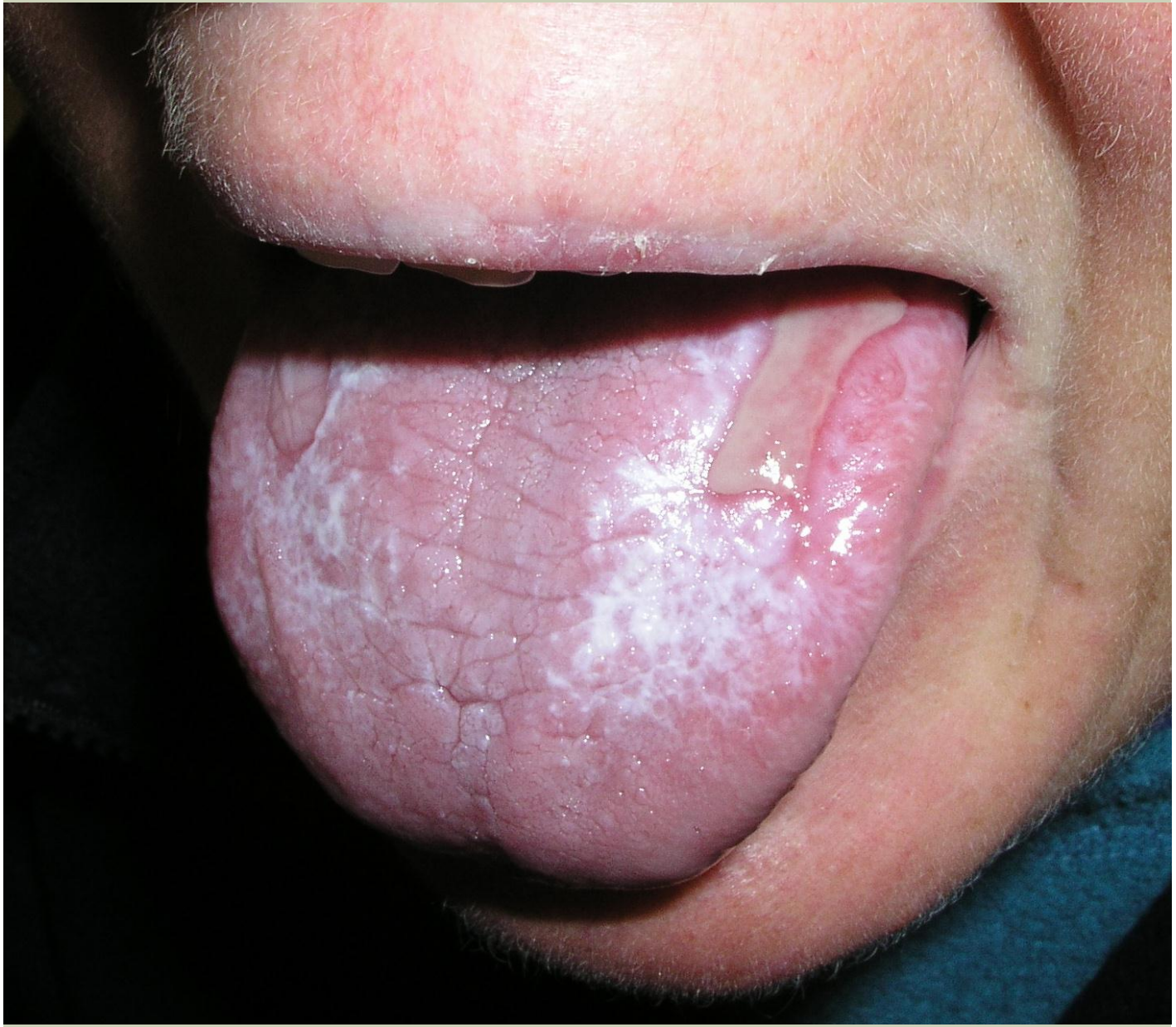

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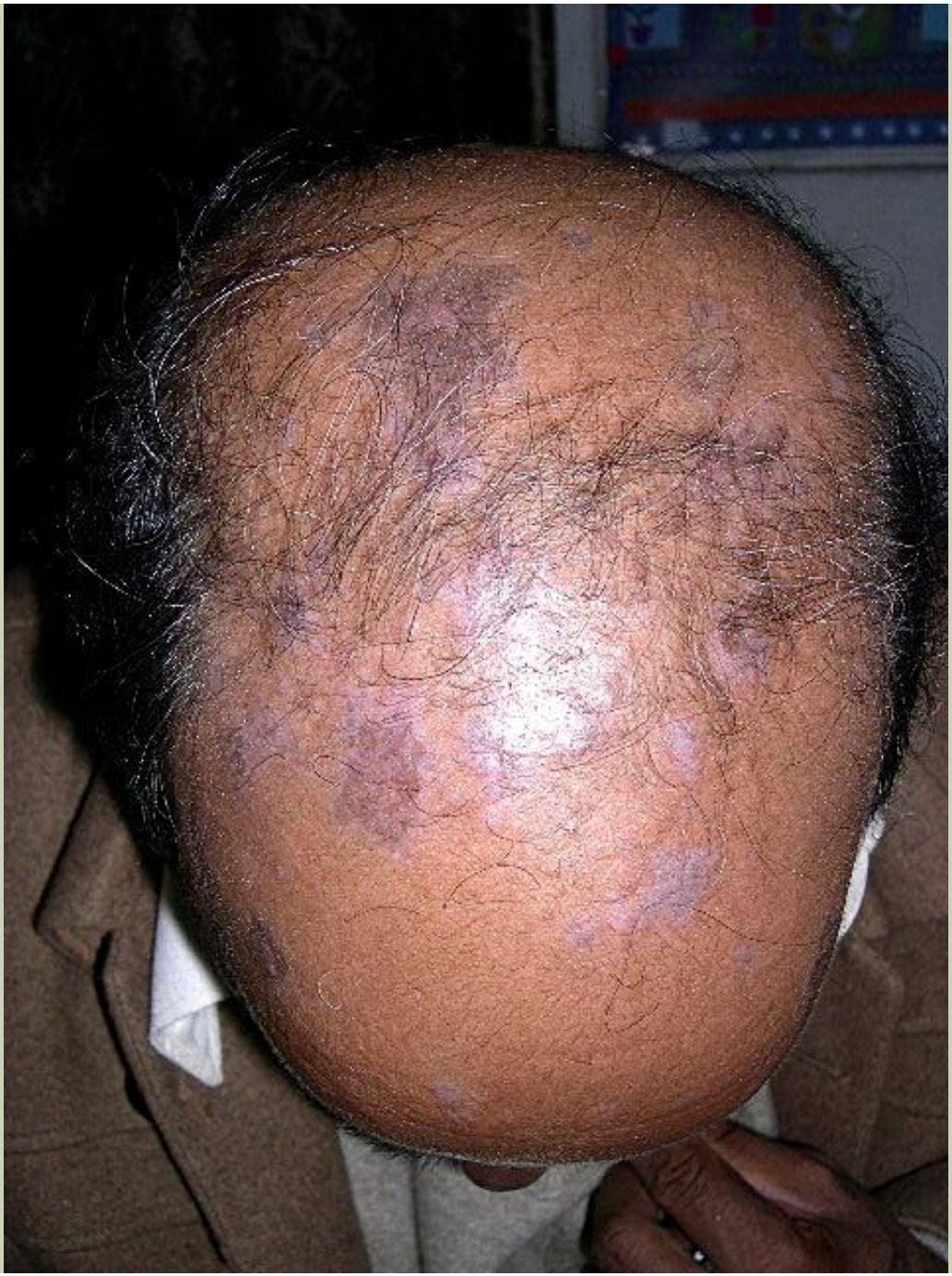


LICHENS PLANUS

May cause scar alopecia

3. PETYRIASIS ROSEA

النخالة الوردية

BACKGROUND

- Definition
  - Acute mild inflammatory exanthem
  - Characterized by the development of erythematous scaly macules on the trunk
- Epidemiology
  - In children and young adult مهمه
  - Increased incidence in spring and autum مهمه
  - PR has been estimated to account for 2% of dermatologic outpatient visits
  - PR is more common in women than in men

PATHOPHYSIOLOGY

- PR considered to be a viral exanthem
- Immunologic data suggest a viral etiology
- Families and close contacts
- A single outbreak tends to elicit lifelong immunity
- مهمة -Human herpes virus (HHV)–7and HHV-6
- PR-like drug eruptions may be difficult to distinguish from non–drug-induced cases
- Captopril, metronidazole, isotretinoin, penicillamine, bismuth, gold, barbiturates, and omeprazole

CLINICAL FEATURES

- Herald patch:
  - a solitary macule that heralds the eruption (herald spot/patch) this appears at first
  - Usually a salmon-colored macule
  - Over a few days it become a patch with a collarette of fine scale just inside the well-demarcated border
- Within the next 1-2 weeks, a generalized exanthem usually appears
- Bilateral and symmetric macules with a collarette scale oriented with their long axes along cleavage lines
- مهمه **Tends to resolve over the next 6 weeks**
- Pruritus is common, usually of mild-to-moderate severity
- Over trunk and proximal limbs

ATYPICAL FORM

- Occurs in 20% of patients
- Inverse PR
- Unilateral variant
- Papular PR
- Erythema multiforme–like
- Purpuric PR

هذا النوع عكس – حيث يظهر في المناطق المغطاه وليس المكشوفه

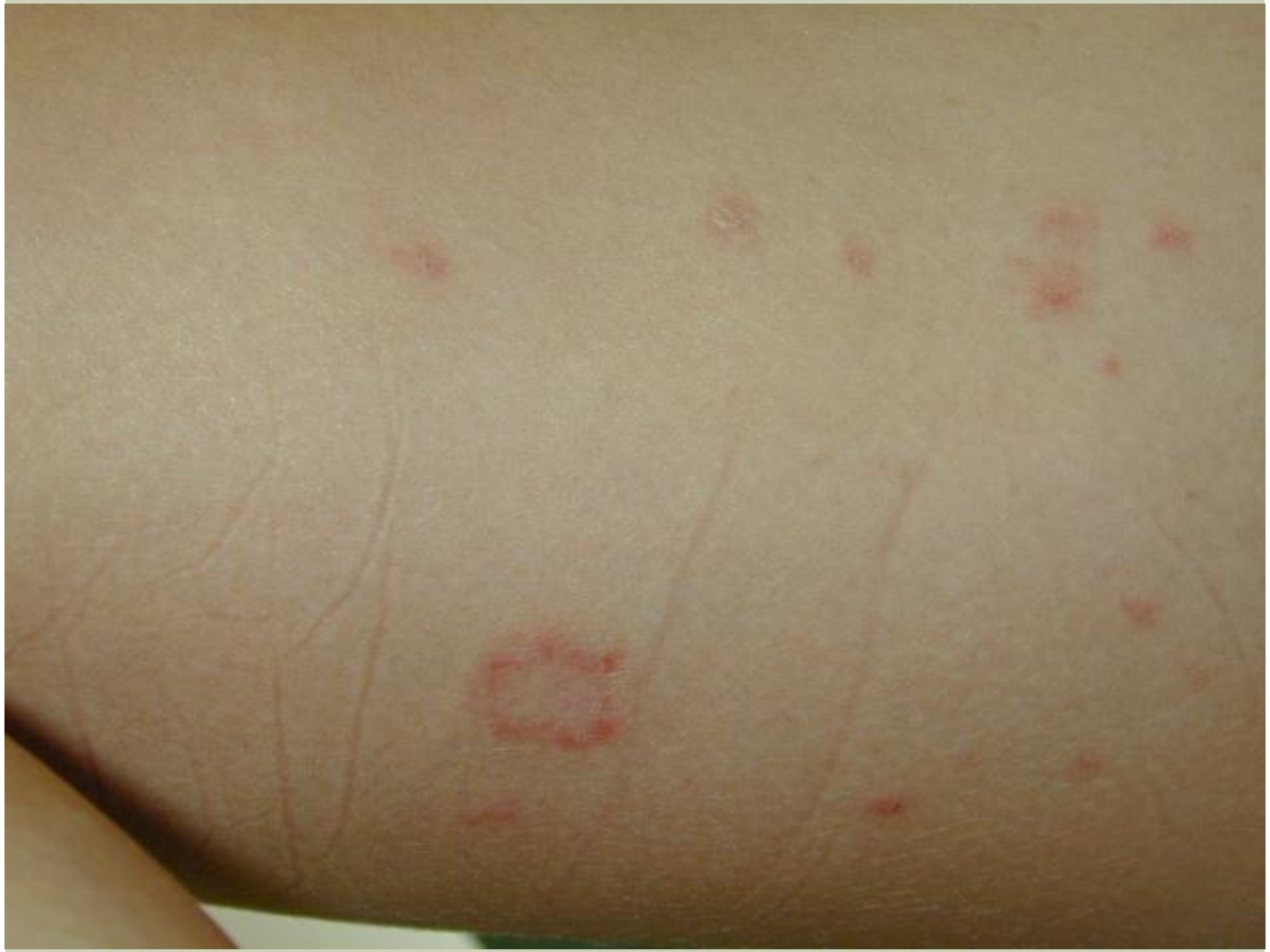
Differentials

- Lichen Planus
- Nummular Dermatitis
  Pityriasis Lichenoides
- Psoriasis, Guttate
  Seborrheic Dermatitis
- Syphilis
- Tine Corporis

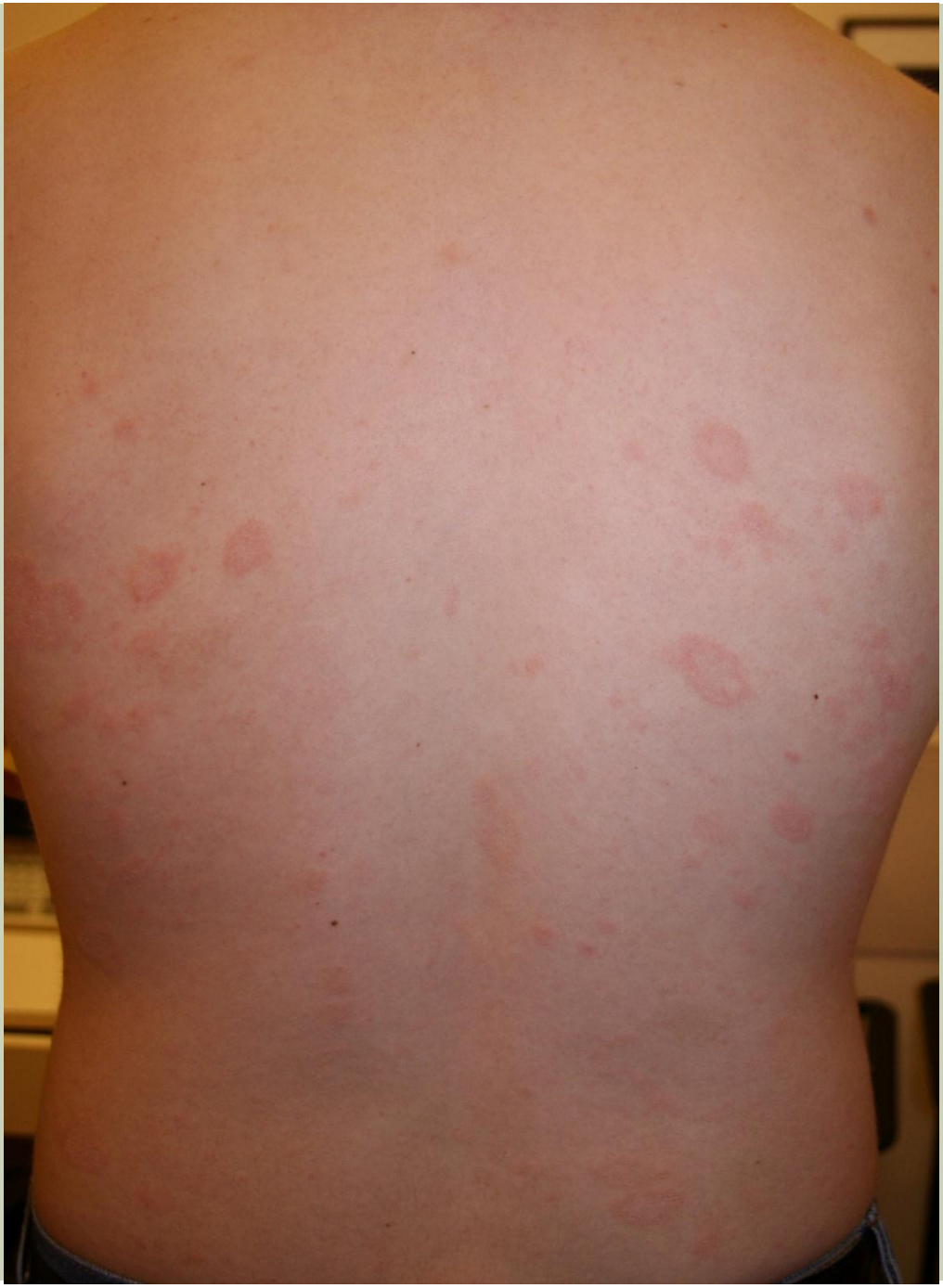
Treatment

Reassurance that the rash will resolve

- Relief of pruritus
- Topical menthol-phenol lotion
- Oral antihistamines
- Topical steroids
- Systemic steroids
- Ultraviolet B (UV-B) light therapy
- In general : it is self-limited



PETYRIASIS ROSEA



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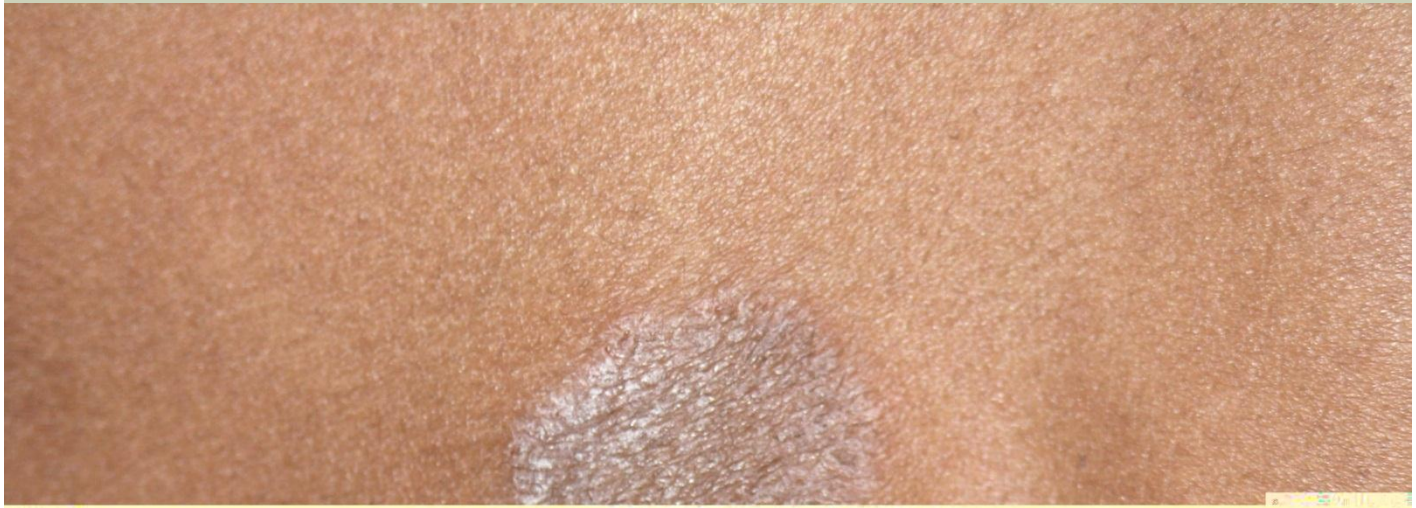

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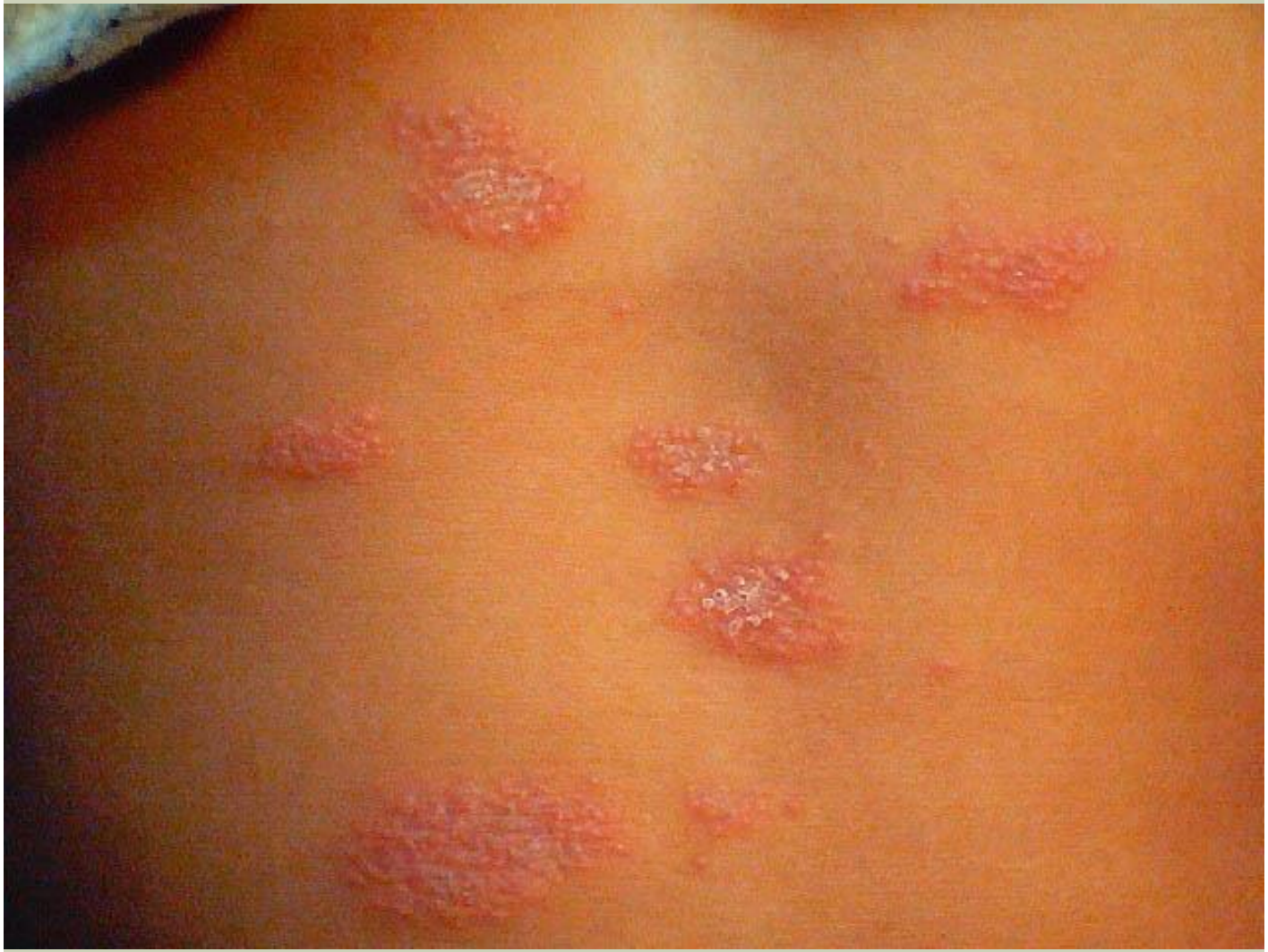

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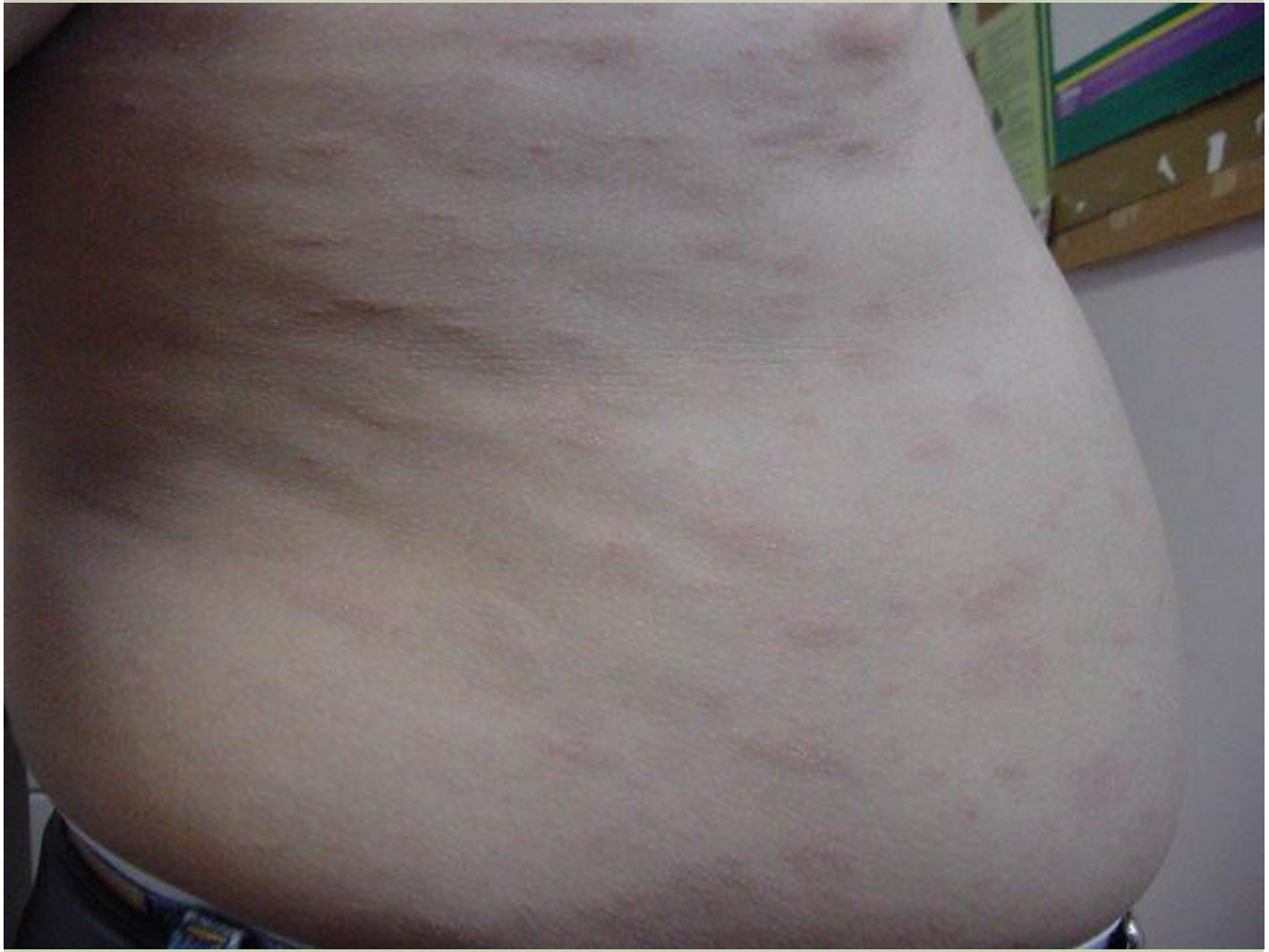

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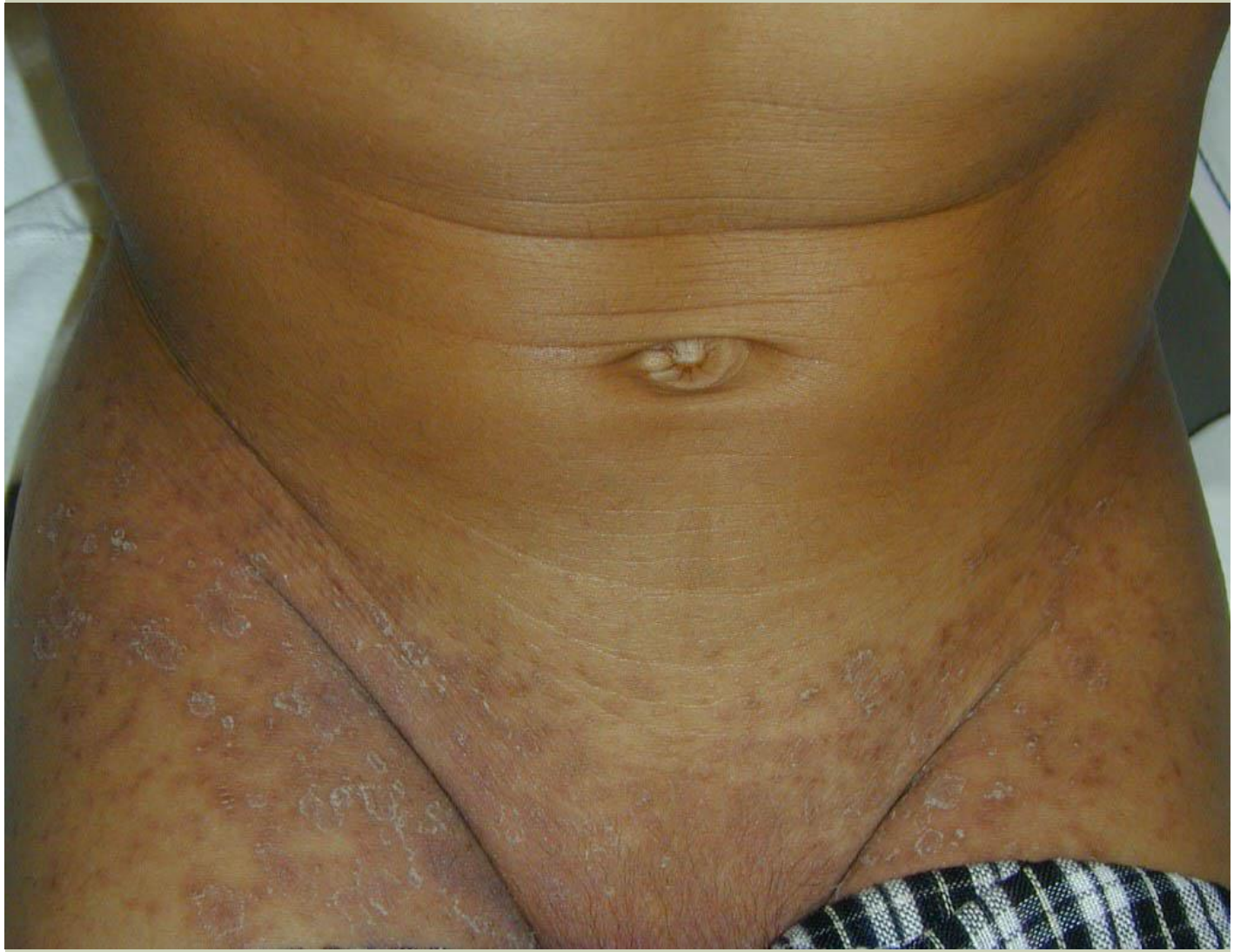

PETYRIASIS ROSEA

THANK YOU