Infiltrated plaques on the trunk

STEVEN KOSSARD FACD

A woman presents with indurated pigmented plaques on her trunk. What is this condition and how can it be treated?

Over a 10-month period, a 39-year-old woman developed asymptomatic, multiple, firm plaques on her trunk. The individual lesions were not well defined. They were associated with accentuated follicular orifices (*peau d'orange*) and patchy hypo- and hyperpigmentation (Figure 1). Skin biopsy showed an expanded dermis with lymphocytic inflammation as well as marked dermal sclerosis that was most evident within the deep dermis and subcutis (Figure 2).

Differential diagnosis

The differential diagnosis of pigmented infiltrated plaques includes the following conditions.

- **Lichen simplex or chronic dermatitis** is pruritic and is usually associated with hyperkeratinisation. Accentuated follicular orifices can occur as a result of rubbing. Skin biopsy will show upper dermal inflammation with epidermal hyperplasia.
- **Lichen amyloidosis** may present as hyperpigmented infiltrated patches, usually associated with a cobblestone or rippled surface. Pruritus is often marked. Skin biopsy shows amyloid deposits in the subepidermal zone. The amyloid is localised to the skin and is not associated with systemic deposits or paraproteins.
- **Scleredema** presents as a diffuse induration of the skin that is often localised to the upper trunk and limbs. Skin folds and skin markings, such as follicular orifices, may be accentuated. Skin biopsy shows expansion of the dermal thickness with interstitial mucinosis, but collagen sclerosis is not a feature. Diabetes may be present or found on investigation.
- **Morphoea (cutaneous scleroderma)** is the correct diagnosis. It may present as solitary, multiple or diffuse plaques of dermal sclerosis. Linear or deep subcutaneous variants have been described. Only a minority of patients will have associated systemic sclerosis or Raynaud's phenomenon. Skin biopsy is useful in establishing the diagnosis.

Treatment

The treatment for localised or isolated plaques of morphoea includes the use of topical corticosteroids, topical retinoids or topical calcipotriol (Daivonex).

More widespread plaques have been treated with long wave ultraviolet light therapy or low dose methotrexate (Ledertrexate, Methoblastin). Some patients have also responded to oral calcitriol or penicillamine (D-Penamine).

Evaluation of treatment is difficult because morphoea can spontaneously remit, but this may be delayed for years.

Keypoint

Indurated pigmented dermal plaques may represent localised scleroderma. MT

Professor Kossard is Associate Professor, Skin and Cancer Foundation and St Vincent's Hospital, Darlinghurst, NSW.

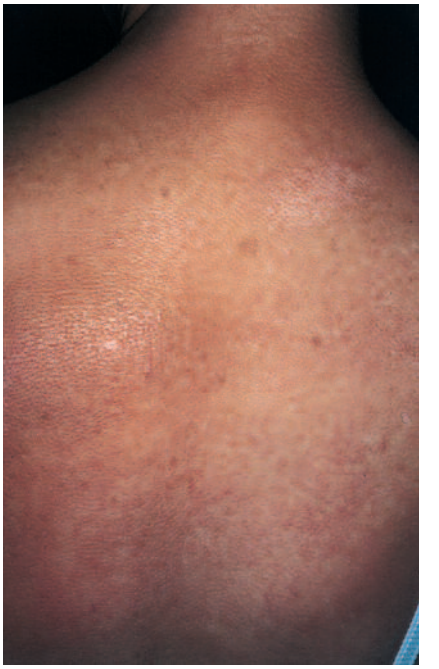

Figure 1. Multiple plaques over the patient's back associated with prominent follicular orifices, hypopigmentation and hyperpigmentation.

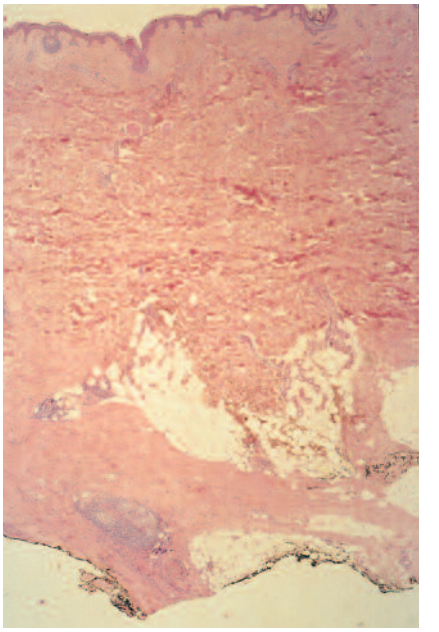

Figure 2. Skin biopsy showing increased thickness of the dermis, with lymphocytic inflammation and deep dermal and subcutaneous sclerosis.