GUTTATE MORPHEA: A CASE REPORT

Wedad Khana, Rasha Alasiri*, Hadeel Alkhatabi

A R T I C L E   I N F O

Keywords:
Morphea
Guttate morphea
Localized
Scleroderma

A B S T R A C T

Scleroderma means hard, thick skin. The term “localized scleroderma” refers to the fact that this group of conditions is “localized” to the skin, with no internal organ involvement. Sometimes, the term “morphea” is used interchangeably with localized scleroderma. It is divided into several subtypes all of which transition through an early inflammatory stage followed by sclerosis and subsequent atrophy. Guttate morphea is one of the rarest subtypes, and it represents less than 1% of the cases worldwide. In our case, we represent a 53-year-old male with guttate morphea. Two years ago, the patient developed hypopigmented non-pruritic papules on the back and shoulders. The clinical presentation, examination, and histopathology of our patient were consistent with guttate morphea.

1. Introduction

Morphea is an inflammatory disorder that causes sclerotic changes in the skin. It is due to extensive storage of collagen, which leads to the thickening of skin layers. Morphea is distinct from systemic sclerosis (scleroderma) which is an autoimmune connective tissue disorder with frequent systemic manifestations. The lesions are usually single or few in number. There is lack of consensus on the appropriate classification system for morphea. Several clinical forms are now recognized including:

- Generalized morphea
- Nodular (keloidal) morphea, subcutaneous morphea (morphea perfunda)
- Linear morphea.
- Guttate morphea (which may be a variant of lichen sclerosus et atrophicus, LSA)

The pathogenesis of morphea is poorly understood. Multiple factors in inducing autoimmunity, genetics, environment and vascular dysfunction may play a role in morphea.

CASE REPORT: HISTORY

A 53 years old Filipino male patient live in Saudi Arabia since 1993, referred electively through OPD because he was complaining of skin lesions since two years. It started at the lower back as hypopigmented flat skin lesion noticed by his wife, associated with minimal itching. There were no scales and no change in color with sun exposure, not tender, there is no bleeding or discharge, not preceded by erythema, in the last two years the lesion increased gradually in number and involved the back and shoulders, but no changes in the sizes or color of individual lesion.

Lesions were not associated with any systemic symptom.

History of exposure to polyvinyl chloride (PCV cement- used in sewage pipe). No history of similar presentation in the family or colleague. Patient sought medical advice one year back. Investigation were done; CXR, CBC and Chemistry was normal, CRP was high 26.7 (0.4-5). He was managed by antifungal cream with no improvement and he didn’t use any other type of medication or herbal remedies. The patient is medically free. Not on any medication. No history of surgeries. He was moderate smoker but stopped 25 years back. He works as Plummer for 12 years. No recent travelling. No history of any known allergy.

PHYSICAL EXAMINATION

Generally patient looks well.

Skin: multiple discrete hypopigmented atrophic patches range from 1mm to 9mm over the back and shoulders, no scales or erythema.

Extremities, trunk and face are not involved.

Nails: normal.

Genitalia: normal.

Scalp: normal.

Oral mucous membrane: normal.
LABORATORY DATA
Hematology and chemistry: normal.
The antinuclear antibody (ANA) & antibodies to single-stranded DNA (ssDNA): no available reagent.

HISTOPATHOLOGY
A 4mm Skin punch biopsy from the upper back taken, showed skin fragment with unremarkable epidermis, the dermis shows minimal infiltration by chronic inflammatory cells.
The mid dermis and the deep dermis show thick collagen bundles arranged haphazardly.
No atypia or malignancy.

DIAGNOSIS
The patient clinical history, examination, labrotry findings and biopsy consistent with Guttate morphea

DIFFERENTIAL DIAGNOSES
Mycosis fungoides, Dyschromia universalis, Post inflammatory hypopigmentation, Vitiligo, Ptryasis versicolor, Sarcoidosis, Secondary syphilis, chemically induced dermal fibrosis.

TREATMENT
The patient was treated with Mometasone furoate cream and Tacrolimus ointment.

Fig. 1, Fig. 2.: multiple, hypopigmented papules ranging from 1mm to 9 mm on the shoulder and back of the patient
Fig. 3a, 3b & 3c: The mid dermis and the deep dermis show thick collagen bundles, crowded and arranged haphazardly.

DISCUSSION
Sclerotic lesions in the skin manifest as firm, bound-down plaques or nodules. However, in morphea, the initial sign of disease is often an inflammatory, erythematous patch or edematous plaque. Some patients may note unexplained pain or itching at the site of disease prior to the development of a
CONCLUSION:

In conclusion, we represent a case of a 53-year-old male patient with multiple discrete hypopigmented atrophic patches on the back and shoulder confirming the diagnosis of guttate morphea, one of the rare subtypes of localized scleroderma.

REFERENCES