PARAPSORIASIS

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Parapsoriasis is a rare cutaneous lymphoproliferative dermatoses that occurs mainly in middle-aged adults, 2/3 of which are male. It is difficult to come to an accepted definition of this disorder due to its varied clinical presentation and lack of specific histopathological findings. Yet, the lesions are usually pink and scaly patches that vary in size, ranging from 1-5cm. This disorder has a chronic course and is commonly resistant to treatment.

There are two types of parapsoriasis; small plaque parapsoriasis (SPP) and large plaque parapsoriasis (LPP). Out of the two types, LPP is considered a premalignant dermatosis with a risk of progressing to **mycosis fungoides** or cutaneous T-cell lymphoma, while SPP is a chronic benign condition. Again, because this disorder is difficult to diagnose, there are no concrete epidemiological statistics. But, of those with LPP, about 10% will progress to a malignant form.

The cause of parapsoriasis is unknown. It is thought that both SPP and LPP represent different stages in a continuum from chronic dermatitis to cutaneous T-cell lymphoma. In addition, dominant T-cell clonality has been seen in many cases of LPP, and only some in SPP. Yet this fact has not proven to increase the risk of malignancy.

SPP typically presents as asymptomatic, pink to yellow-brown, round or oval macules or patches, ranging from 2-5cm, with variable scaling. The lesions mainly occur on the trunk, flanks and proximal extremities. When examined under a microscope, there are very nonspecific findings; mild spongiosis, parakeratosis, scale and exocytosis of small lymphocytes. There is also a variant of SPP, called digitate dermatosis. The lesions in this case are considered elongated patches, with an atrophic cigarette paper like surface, which occur on the flanks along the skin cleavage lines.

In comparison, LPP presents as large irregularly shaped patches, typically dusky red or brown with fine scale. There is usually epidermal atrophy and the lesions often appear on non-sun exposed areas, such as; the buttocks, thighs, lower trunk, flexural surfaces, breasts and inframammary areas. Microscopically, there is psoriasiform epidermal hyperplasia, poiklodermatous areas, vacuolization in the basal layer, and brisk lymphocytic infiltration. Pautrier microabscesses, clusters of atypical lymphocytes, are a classic sign of mycosis fungoides, when absent, there is more inclination to diagnose LPP.

To reach a definitive diagnosis, there must be a proper clinical presentation as described above and a skin **biopsy**. The skin biopsy of choice is typically a punch biopsy to see the full thickness of the skin. It is recommended to do multiple skin biopsies in a variety of areas because of the diverse morphology. In addition, it is also recommended to do them overtime to monitor their progression, especially in the case of LPP.

Treatment for SPP begins with moderate to high potency **topical corticosteroids**for 8-12 weeks. If results are unsatisfactory, which is defined as less than 50% clearance, then the addition of **phototherapy** is considered 2-3 times a week. The treatment of LPP begins similarly in that topical corticosteroids are used. Yet, this first line of treatment is used with a high or super high potency steroid for about 12 weeks. If there is extensive skin involvement, then phototherapy is additionally used at the start of treatment 2-3 times a week. Follow up with SPP patients are annually, yet follow up with LPP patients is every 6 month due to the possible progression to malignancy.

This information has been provided to you compliments of the American Osteopathic College of Dermatology and your physician.