



Table 15.6 Differential diagnosis of psoriasis.

Disease	Differential points
Seborrheic dermatitis	The clinical findings resemble those of psoriasis, but the affected sites are relatively localized at seborrheic areas.
Chronic eczema	Various, localized skin lesions including erythema, scales, papules, and blisters. Intense itching. The lesions are less clearly margined than in psoriasis.
Parapsoriasis	Pigmentation and atrophy are often present. Histopathological differentiation may be necessary.
Pityriasis rosea (Gibert)	Psoriasis-like lesion appears after manifestation of the first eruption, and disappears in 1 or 2 months.
Mycosis fungoides	Clinical findings may resemble those of psoriasis. Histopathological infiltration of atypical lymphocytes to the epidermis (Pautrier's microabscess).
Syphilitic psoriasis	Psoriasis-like eruptions on the palms and soles. History-taking and serologic test for syphilis are important.
Drug eruption	History-taking on drugs and tolerance test are conducted.
Ankylosing spondylitis	Psoriasis-like eruption in some cases; differentiation from psoriatic arthritis is important.

3) Pustular psoriasis ★ ★

Pustules are the main clinical feature. The disorder is subdivided into a generalized type and a localized type (Table 15.7). In the generalized type, fever, systemic fatigue and bodily chills accompany erythema on which multiple sterile pustules occur and coalesce. The pustules rupture spontaneously to form erosions. Exudative fluid may cause hypoproteinemia, leading to marked systemic aggravation in some cases. It may occur in the course of psoriasis vulgaris, or it may develop suddenly without any history of psoriasis (Fig. 15.26).

4) Psoriatic erythroderma ★

Psoriatic skin lesions appear all over the body and become erythroderma. Proteins are consumed in large amounts in the lesions. The horny cell layer forms incompletely, bringing hypoproteinemia, dehydration and electrolyte abnormality.

5) Psoriatic arthritis ★ ★

Arthritis symptoms may accompany psoriasis. The majority of cases are the peripheral type, which affects distal interphalangeal (DIP) joints. There is a type in which vertebra and sacroilitis are involved. Arthritis proceeds without psoriatic skin lesions in many cases. There is association with the HLA-Cw6 gene.

2. Pityriasis rubra pilaris ★

Clinical features

Follicular inflammatory papules of 2 mm to 3 mm in diameter

Clinical images are available in hardcopy only.

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Fig. 15.24-3 Psoriasis vulgaris on the arm and buttocks.

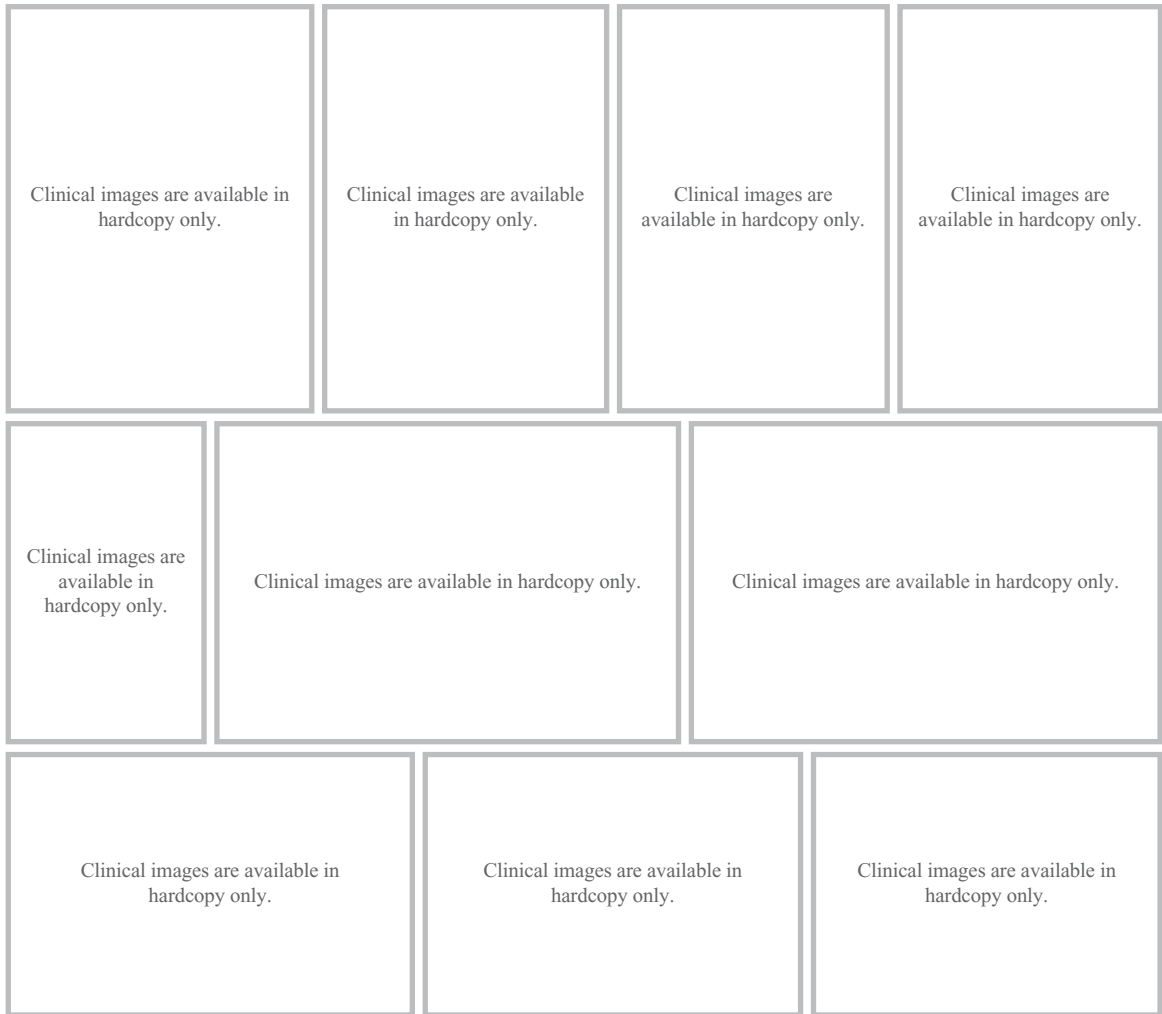


Fig. 15.24-4 Psoriasis vulgaris on the extremities and nails.

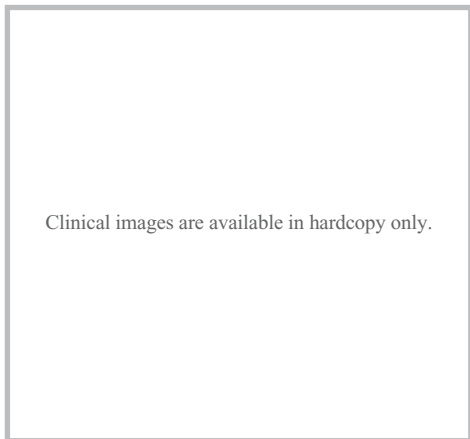


Fig. 15.25-1 Guttate psoriasis on the trunk.
Multiple keratotic erythema of 1 cm in diameter occur.

occur on the fingers, extensor surfaces of the extremities, and upper abdomen. The papules are flushed and have a white keratotic acuminate plug (keratotic plug) in the center (**Fig. 15.27**). When produced on the elbows and back of the knees, these eruptions coalesce to present sharply circumscribed orange psoriatic plaques to which scales are attached. Multiple white keratotic papules also occur with a coarse, grater-like appearance. Highly diffuse keratosis is seen on the palms and soles. It is usually asymptomatic.

There are cases in which the eruptions may spread and become erythroderma, and cases with reduced dark adaptation resulting from lack of vitamin A.

Pathogenesis, Epidemiology

The etiology is unknown. There are peaks of occurrence at infancy and in the fifth decade of life; pityriasis rubra pilaris is divided into a juvenile type and an adult type. Most of the juvenile

Table 15.7 Classification of pustular psoriasis.

Classification		Clinical findings				
Localized type	Localized pustular psoriasis	Pustules are localized around the plaques of psoriasis vulgaris.				
	Pustular psoriasis with generalized skin lesion	<table border="0"> <tr> <td>Palmoplantar pustulosis (PPP)</td> <td>Pustules are localized bilaterally on the thenar and arch of the foot.</td> </tr> <tr> <td>Acrodermatitis continua of Hallopeau</td> <td>Often occurs secondarily after an external injury. Pustules and nail deformity occur on the tips of fingers or toes on one side of the body.</td> </tr> </table>	Palmoplantar pustulosis (PPP)	Pustules are localized bilaterally on the thenar and arch of the foot.	Acrodermatitis continua of Hallopeau	Often occurs secondarily after an external injury. Pustules and nail deformity occur on the tips of fingers or toes on one side of the body.
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Generalized pustular psoriasis (GPP)	<table border="0"> <tr> <td>Acute generalized pustular psoriasis (von Zumbusch psoriasis)</td> <td>Psoriasis vulgaris progresses to be accompanied by systemic symptoms. Poor prognosis.</td> </tr> <tr> <td>Subacute, circular pustular psoriasis</td> <td>The systemic symptoms are milder than those of von Zumbusch psoriasis.</td> </tr> </table>	Acute generalized pustular psoriasis (von Zumbusch psoriasis)	Psoriasis vulgaris progresses to be accompanied by systemic symptoms. Poor prognosis.	Subacute, circular pustular psoriasis	The systemic symptoms are milder than those of von Zumbusch psoriasis.	
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Subacute, circular pustular psoriasis	The systemic symptoms are milder than those of von Zumbusch psoriasis.					
	Impetigo herpetiformis	Pustules are generalized during the middle and last stages of pregnancy.				



Fig. 15.25-2 Guttate psoriasis on the buttocks.

cases are familial and autosomal dominantly inherited. A subtype caused by HIV has been reported in recent years.

Pathology

The follicles are dilated and filled with keratin. The peripheral epidermis is thickened and there is parakeratosis in some parts. Complete keratinization alternates with incomplete keratinization. Polymorphonuclear cells do not infiltrate into the epidermis, which is useful for differentiation from psoriasis. Vasodilation and lymphocytic infiltrate are observed in the upper dermis.

Differential diagnosis

Pityriasis rubra pilaris should be differentiated from psoriasis, cutaneous T-cell lymphoma, seborrheic dermatitis, drug eruption, ichthyosis and contralateral progressive erythrokeratoderma.

Treatment, Prognosis

Both types heal spontaneously, within a year in the juvenile type and within 2 to 3 years in the adult type. The symptomatic therapies are application of urea ointments, salicylic acid petrolatum ointments, and active forms of vitamin D₃ ointments. Oral retinoid is also useful.

3. Parapsoriasis en plaque ★
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It is a generic term for diseases that produce multiple psoriasis-like keratotic erythema. The pathogenesis is unknown, but it is thought to be different from that of psoriasis. Some large-plaque