

SPOROTRICHOID ATOPIC PRURIGO. A COMMON CONDITION WITH AN UNUSUAL CLINICAL PRESENTATION

SPOROTRICHOID ATOPIC PRURIGO. CZĘSTE SCHORZENIE O NIEZWYKŁEJ PREZENTACJI KLINICZNEJ

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Abstract

Prurigo is a chronic pruritic papular dermatitis. It is a benign condition, acute or chronic. It is more frequent in spring and summer, affecting patients with a low socio-economic status.

Streszczenie

Świerzbiączka jest przewlekłą swędzącą grudkową dematozą. Może mieć łagodny, ostry lub przewlekły przebieg. Występuje częściej w okresie wiosenno-letnim, głównie wśród osób o niskim statusie socjoekonomicznym.

Key words: prurigo; insect bites; itching

Słowa kluczowe: świerzbiączka; ugryzienie owada; świąd

Introduction

Prurigo is a syndrome characterized by papular lesions and itching, with an acute or chronic evolution, relatively easy to diagnose by clinical history. Its pathogenesis is due to multiple causes such as insect bites, foci of infection, parasites, etc. It is simple to diagnose and treat but it may have atypical clinical presentation.

Case Report

67-year-old white male, gardener, with a history of asthma. He presented an injury of two weeks of evolution in the left armpit, not related to trauma or insect bites, painful and itchy, crusty and with purulent discharge.

Physical examination: erythematous-violaceous nodules, 2 to 5 cm. in diameter with central erosion covered with blackish crust and purulent discharge, which follow a linear path in the left axillary region (Fig. 1). No regional lymphadenopathy.

Histopathology: epidermal acanthosis, foci of parakeratosis, hypergranulosis and mild spongiosis. Superficial and deep inflammatory infiltrate of mononuclear cells and numerous eosinophils (Fig. 2, 3). The infiltrate reaches the hypodermis.

The direct mycological examination and culture of discharge and scaling of lesions was negative for fungi.

Routine laboratory normal.

With the diagnosis of atopic prurigo the patient was treated with topical betamethasone dipropionate 0.064 gr. + 0.1 g gentamicin, and cephalexin 500 mg. VO, for 10 days.

The therapeutic response was favorable with complete remission of lesions a month after starting the specific treatment (Fig. 4).



Figure 1. Clinic. Rounded nodules with central erosion covered with blackish crust and purulent discharge, which follow a linear path in left axillary region

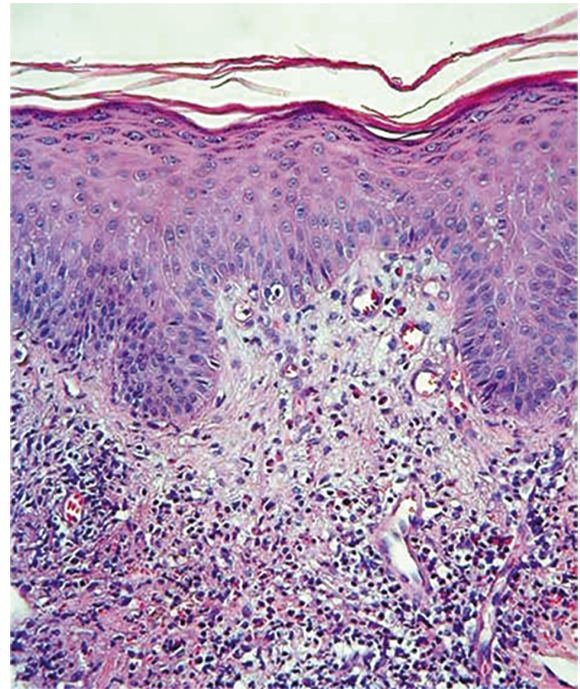


Figure 2. Histopathology. Epidermis with acanthosis, hypergranulosis and focal parakeratosis. Mild spongiosis

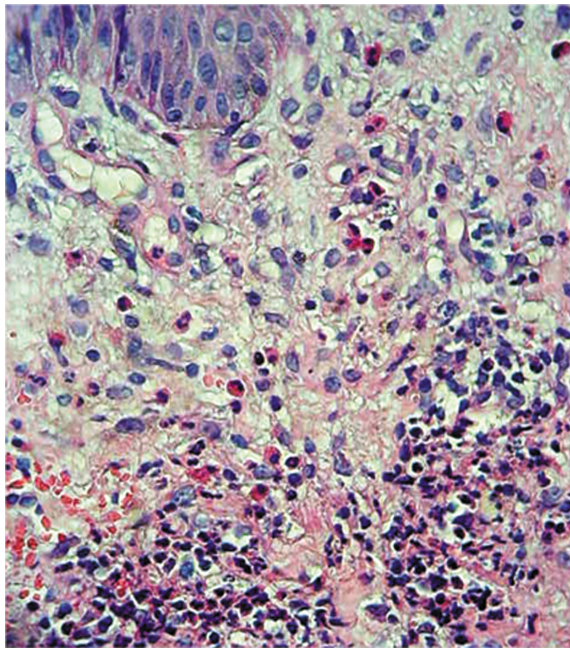


Figure 3. Histopathology. Papillary dermis with mononuclear inflammatory infiltrate and numerous eosinophils



Figure 4. Clinical evolution. Complete remission of lesions after a month of treatment

Discussion

Prurigo is a disease whose elemental lesion is the papule and the primary symptom is itching [1,2]. It is a reaction that usually affects male (3:1) children aged 1 to 7 years, without racial preference. Predominates in tropical countries, like ours, during the warmer months and is seen mainly in lower socioeconomic status [3]. The lesions are caused by insect bites. The most frequently involved are: *Cemex lectularius* (bedbug) and *Pulex Irritians* (fleas). Other ectoparasites involved may be flies, trombidias, tung and ticks [3,4]. Early lesions of prurigo by insect are due to a type I hypersensitivity response caused by the release of IgE that

is clinically manifested by rash, later involving in a type 4 hypersensitivity mechanism, dependent on T lymphocytes, which causes late lesions causing papules [5].

Three phases are described in terms of response mounted to the sting of an insect: at first the person is unresponsive to the bite for lack of awareness, and after a history of previous bites and response there has started an awareness, and finally, in adulthood desensitization is established after many bites. In some ways this may explain why children under one year have not been exposed, hardly react to insect bites, one case presented hemorrhagic macula showing the location of the lesion and is clearly secondary to trauma and almost always

asymptomatic, whereas in the period between 2 and 7 years desensitization occurs following the bites being more common so the insect prurigo at this age, much less common in adults [3].

Classification [4]:

- Scrofula or Prurigo of Children: Common between the first and second year of life, caused by a hypersensitivity reaction to insect bites toxins. It is manifested by sudden onset of hives in the middle and papules over tiny vesicles accompanied by itching.
- Prurigo Simple: common in adolescents and adults, also produced by a hypersensitivity reaction to various causes such as insect bites, light, hormonal disorders, pregnancy, oral contraceptives, and so on. Clinically it is similar to Scrofula.
- Prurigo Eczema: in adults, may be in the form of atopic eczema, manifesting as lichenified plaques quickly, accompanied by intense and persistent itching.
- Nodular Prurigo (Hyde): chronic condition of unknown etiology but different states may induce their appearance, for example, internal diseases, kidney failure or psychiatric disorders, AIDS, Hepatitis C, mycobacteria, Helicobacter pylori, Strongyloides stercoralis [2,7,8]. It is characterized by papulo-nodular lesions 0.5 to 3 cm. in diameter, with abrasions on the surface, with intense itching with chronic and no tendency to regression.

The initial lesion is a wheal acute prurigo, often crowned by a central dark spot or a blister. After several hours papules form firm, glossy, 3 to 10 millimeters in diameter, grouped, symmetrical distribution and very itchy. They may be excoriated, lichenified, or overinfected with crusting on the surface. The lesions recur in outbreaks of between 10 and 20 injuries, and are in various stages of evolution. Most of the lesions persist between 2 and 10 days with red or redness persists or postinflammatory pigmentation after resolution. Eventually, scar tissue can develop. The acute prurigo is not associated with systemic symptoms or lymphadenopathy or lymph neighbors [5].

Lesions that are covered parts suggest bedbugs or fleas, which are not covered in parts, flying insects such as mosquitoes or flies. The usual complications are contact dermatitis and impetigo [3].

Sensitized patients may have a generalized rash to be bitten again to reactivate the previously affected areas. The evolution of disease outbreaks is irregular intervals with changes in environment [5].

The differential diagnosis of scabies should be made, acropapulosis of childhood chickenpox and atopic dermatitis [1].

For diagnosis, biopsy is not required. In the epidermis there is spongiosis or intercellular edema, epidermal necrosis can be found, sometimes there are real blisters. The dermis is infiltrated by lymphocytes, histiocytes, and many eosinophils. Many times the small nerves are thickened [3].

Treatment of prurigo is based on [6]:

General measures:

- Explain to patients the natural history of disease, atopic predisposition, age of onset, chronicity and evolution is fundamental.

- Recommend use of pajamas with long sleeves and pants, close windows and placing mosquito netting when sleeping, and avoid animals or plants within the sleeping quarters.

- Use of insecticides regularly with preventive measures.

Topical measures:

- Steroids for three or four days in early stages of the disease to reduce the itching and blistering.
- Pasta and creams inherent drying.
- Solutions with menthol, phenol or camphor.
- If infection were administered aggregate an antiseptic or antibiotic ointment.

Systemic actions:

- Antihistamines such as hydroxyzine (1mg/kg/day), chlorpheniramine or other non-sedating.
- Thiamine excretion VO which prevents the skin from insect bites (200 and 600mg/day).
- Intravenous immunoglobulins for atopic prurigo nodularis [9].
- Narrowband UVB phototherapy [10].

Conclusion

We present the case for the unusual clinical presentation in an adult patient (bulky lesions showed a rare anatomical site), having to resort to auxiliary diagnostic methods, and the satisfactory therapeutic response.

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