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DERMATOSE CINZENTA ASSOCIADA COM USO ORAL DE ANTIDEPRESSIVO

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RESUMO – Dermatose cinzenta ou eritema discrômico persistente (EDP) é uma síndrome clínica de classificação controversa. A condição é rara no Brasil. Foi descrita inicialmente em El Salvador, mas também tem sido encontrada em vários países da América do Sul e em outras regiões do mundo. Sua etiologia é desconhecida, porém alguns autores acreditam que ela representa uma apresentação difusa de erupção medicamentosa fixa, enquanto outros a consideram como uma variante do líquen plano pigmentoso por apresentar achados histopatológicos semelhantes. Clinicamente apresenta-se com lesões na forma de numerosas máculas cinza de tamanhos variados. Não há tratamento eficaz até o momento, no entanto, os benefícios foram relatados com o uso de clofazimina. Neste relato de caso, os autores descrevem um caso de *ashy dermatose* associada ao uso de inibidores específicos da recaptação da serotonina.

PALAVRAS-CHAVE – Dermatose cinzenta; Eritema; Hiperpigmentação; Líquen plano.

ASHY DERMATOSIS ASSOCIATED WITH ORAL ANTIDEPRESSANTS

ABSTRACT – *Ashy dermatosis or erythema dyschromicum perstans (EDP) is a clinical syndrome with a controversial classification. The condition is rare in Brazil. It was initially reported in El Salvador but has also been found in several South American countries and in other regions of the world. Its etiology is unknown; however, some authors believe that it represents a diffuse presentation of fixed drug eruption, while others consider it to be a variant of lichen planus pigmentosus in view of the similar histopathological findings. Clinically, the condition presents with lesions in the form of numerous gray macules of varying sizes. There is no effective treatment to date; however, benefits have been reported with the use of clofazimine. In this report, the authors describe a case of ashy dermatosis associated with the use of serotonin-specific reuptake inhibitors.*

KEY-WORDS – *Skin diseases; Erythema; Hyperpigmentation; Drug eruptions; Lichen planus.*

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INTRODUCTION

Ashy dermatosis or erythema dyschromicum perstans (EDP) is a hypermelanotic disorder first described by Ramirez in 1957. It is characterized by bluish-grey macules that develop on the skin of healthy individuals[1,2]. It is a controversial entity, with some authors considering EDP to represent a variant of lichen planus pigmentosus in view of the overlapping clinical and histologic features of these two conditions. However, according to the literature, there are significant clinical differences between these two dermatoses, giving strength to the hypothesis that they represent two separate conditions[3,4].

Ashy dermatosis occurs predominantly in dark skinned individuals, principally women. It affects individuals of all ages. Most patients present with slowly progressing gray, brownish-gray or bluish-gray macules and patches. The presence of an active red border or a peripheral erythematous margin of 1-2mm in diameter is uncommon. The most commonly affected sites are the neck, face, trunk and proximal arms, with distribution being usually symmetric. No reticular pattern or pruritus is found with ashy dermatosis. Although the condition may clear up spontaneously, particularly in prepubertal children, the lesions usually follow a chronic and insidious course and persist for years in adults. Lichen planus pigmentosus is characterized by papules, a reticular pattern and occasional pruritus, with the lesions affecting sun-exposed and flexural areas. These two dermatoses are histologically similar; however, according to the literature, hyperkeratosis, hypergranulosis and lichenoid infiltrate are absent in ashy dermatosis[2-6].

Fixed drug eruption is an acute drug reaction that improves following withdrawal of the causative drug, leaving a residual hyperpigmentation. Several drugs may induce fixed pigmented erythema, including chlormezanone, penicillin, acetylsalicylic acid, diclofenac, indomethacin, mefenamic acid, ibuprofen, nimesulide, clarithromycin, levamisole, phenobarbital and sulfamethoxazole-trimethoprim, among others[7].

In ashy dermatosis, clinical differential diagnoses include, principally, a fixed drug eruption with multiple lesions and postinflammatory hyperpigmentation secondary to a lichenoid drug eruption, pityriasis rosea, small plaque parapsoriasis, Addison's disease, hemochromatosis, lichen planus and erythema multiforme. Less common conditions that should be included in a differential diagnosis are macular forms of urticaria pigmentosa, pinta and leprosy[2,7].

Up to the present date, a rigorous epidemiologic study examining potential triggers has yet to be performed. Furthermore, the possibility has been raised that some patients with multiple fixed drug eruptions may be misdiagnosed as having EDP, emphasizing the need to carefully review all medications, including over-the-counter drugs and herbal remedies.

CASE REPORT

A 60-year-old Latin-American woman presented at an outpatient clinic with dark spots on her abdomen that had been present for the preceding 8 months. The lesions had gradually progressed to her forehead, back,

arms and legs. The patient denied itching, numbness or scaling on the lesions. She also reported having been in treatment for hypothyroidism for the past 15 years and for depression for the past year. Depression was initially treated with fluoxetine, this medication being replaced by paroxetine hydrochloride after 6 months. The patient's family history revealed nothing of significance. Dermatological examination showed numerous confluent bluish-gray macules of varying sizes and shapes located on the patient's neck, abdomen, back and right arm (Figs. 1, 2 and 3). No peripheral erythematous ring was present in the lesions. The diagnostic hypotheses taken into consideration were fixed drug eruption, ashy dermatosis and lichen planus. An incisional biopsy was performed on a lesion located on the right arm. Histopathology revealed necrotic keratinocytes, pigmentary incontinence, melanophages and mild perivascular mononuclear infiltrate (Fig. 4). Based on the association of the clinical manifestations and histopathological findings, a diagnosis of *erythema dyschromicum perstans*

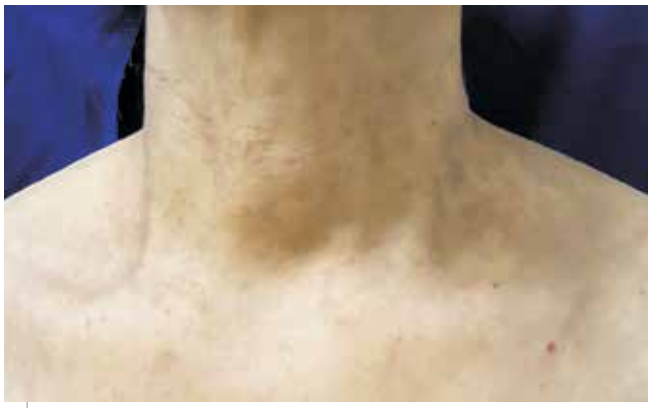

Fig 1 - Numerous confluent bluish-gray macules of varying sizes and shapes located on the neck.

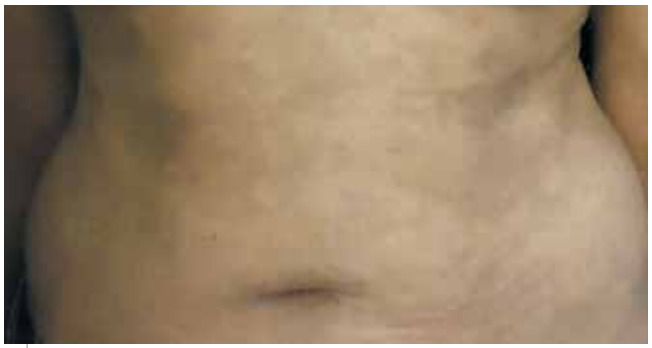

Fig 2 - Numerous confluent bluish-gray macules of varying sizes and shapes located on the abdomen.

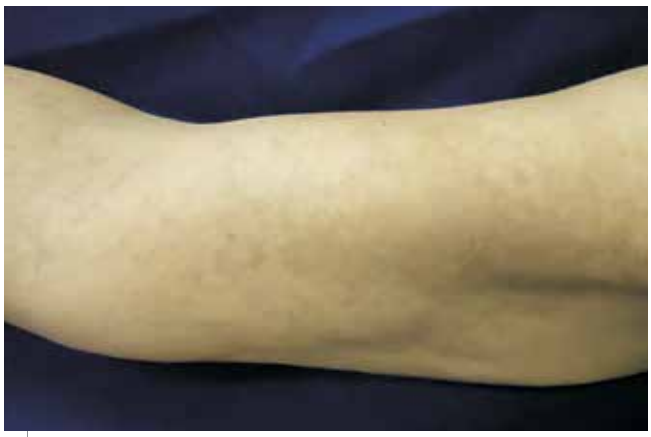

Fig 3 - Numerous confluent bluish-gray macules of varying sizes and shapes located on the arm.

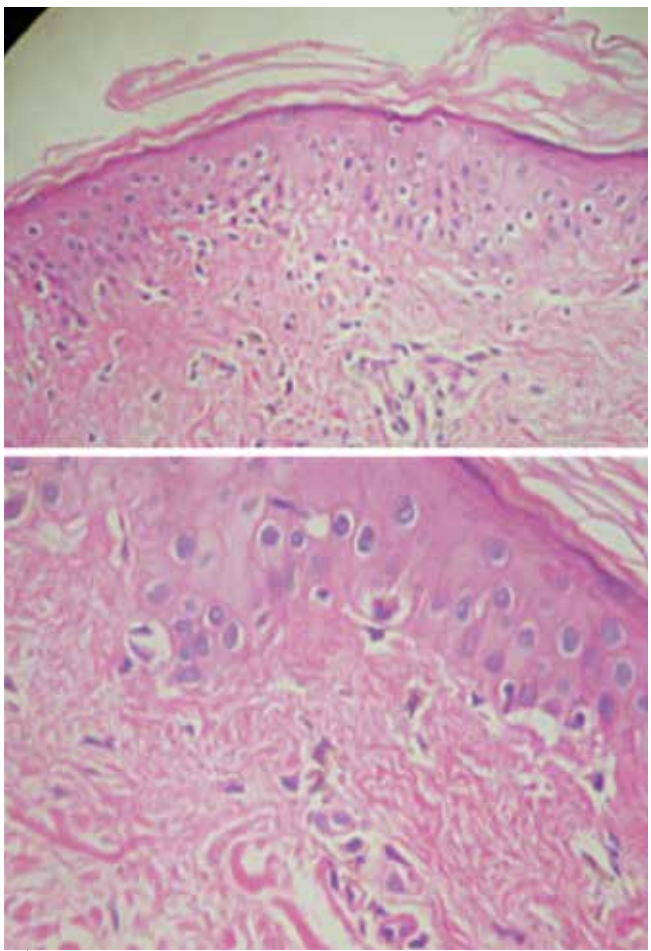

Fig 4 - Necrotic keratinocytes, pigmentary incontinence, melanophages and mild superficial perivascular mononuclear infiltrate.

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was established. The patient was advised to discontinue the antidepressant, avoid exposure to the sun and use sunscreen regularly.

DISCUSSION

Ashy dermatosis is classified either as a non-infectious inflammatory disease or as acquired hyperpigmentation. Its etiology is unknown; however, associations with endocrinopathies, nematode infestations, exposure to pesticides, HIV infection, vitiligo and chronic hepatitis C, as well as an allergy to cobalt and to contrast agents used in radiology, have been reported. It has been associated with a wide variety of other diseases, and these diagnostic possibilities can be ruled out on clinical and histological grounds. Histological changes are non-specific, and include a thinned epidermis, basal cell vacuolization, colloid bodies, perivascular lymphohistiocytic infiltrate, pigmentary incontinence and melanophages.

In almost all cases, pigmentation is permanent, although a slight attenuation may occur over many months. In general, the treatments proposed in cases of EDP are unsuccessful and results are disappointing. They include protection from the sun, topical corticosteroids, retinoids and vitamin C, chemical peels, oral antibiotics, vitamin A, dapsone, antimalarial drugs, griseofulvin and corticosteroids[2,5,7]. Based on a case series, clofazimine was reported to be successful for the treatment of EDP at a dose of 100mg three times per week for three to five months[9,10].

Considering the clinical history, dermatological examination and histopathology of this patient, the present report adds one more case to the group of fixed drug eruptions.

The low prevalence of this disease in Brazil, together with the use of antidepressive drugs as a possible triggering factor, constitute the two main features that make this case uncommon or unique in the medical literature.

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