

The Differential Diagnosis of Psoriasis Vulgaris

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Abstract

Psoriasis is a chronic, relapsing dermatose characterized by erythematous scaly plaques. Histopathological signs parakeratosis, losing of granular layer, acanthosis, papillomatosis, microabscess, capillary proliferation, excessive mitosis up to 50 fold.

Differential diagnosis of psoriasis should be done with all bacterial-viral diseases, tumors, precancerous lesions, mycosis fungoides, subacute lupus erythematosus, allergic and atopic dermatitis, lichen planus, tinea pedis.

In the differential diagnosis of psoriasis, Vulgaris should be thinking generally five dermatological diseases. 1. Nummular eczema, 2. MF, 3. Pityriasis rubra pilaris, 4. Duhring's disease (dermatitis herpetiformis), 5. Bowen's disease.

In this review will be discussed clues of differential diagnosis of psoriasis.

Keywords: Psoriasis vulgaris; Differential diagnosis

Psoriatic plaques are characterized by

- Raised and easily palpable
- Irregular to oval in shape
- One to several centimeters in size
- Well-defined, with sharply demarcated boundaries
- Full red color, but sometimes carry blue or violaceous tint
- Have a dry, thin, silvery-white or micaceous scale
- Shows high degree uniformity
- Locations are scalp, trunk, limbs with a predilection for extensor surfaces such as the elbows and knees.
- Symmetric distribution
- Pruritus
- Nail involvement
- Inverse type involvement
- Association of arthritis [1].

Psoriatic plaques have tree peculiar morphologic elements erythema, infiltration, and desquamation. Differential diagnosis should be done with all inflammatory, neoplastic and infection diseases. In the differential diagnosis of psoriasis vulgaris generally, five dermatologic diseases should think.

Nummular eczema (rounded, circular desquamative erythematous lesions covered with vesicles, crusts, and scales, very itchy) Patients have whether atopic or allergic diathesis. Epicutaneous allergy tests are frequently positive.

Mycosis fungoides a form of T-cell lymphoma shows erythematous patches little infiltrated and finely desquamating. The worst response to treatment should be suggested to carry out a biopsy in these cases which are crucial for the diagnosis [2,3].

Pityriasis rubra pilaris in typical cases follicular papules and infiltrating scales are observed as well as typical hyperkeratosis.

Duhring's disease (dermatitis herpetiformis), its bilateral symmetric localization on extensor surfaces of the limbs. With close-up observation will show papules and vesicles on the erythematous skin. In eruptive phase with crusts full of serum and blood and lichenification due to scratching. In the chronic phase, this disease is constantly very itchy.

Bowen's disease squamous cell carcinoma inside of the skin erythematous little infiltrated, finely desquamating mainly single patches. Showing no improvement to photo and local therapy [3].

Other Diseases in Differential Diagnosis

Lichen planus

Lichen planus characterized by violaceous, rectangular, shiny papules and sometimes scales on top of the papules and Wickham network. Plaque-type lichen resembles psoriasis and differential diagnosis should be done by biopsy and pathological examination. Histopathological signs of psoriasis are parakeratosis, acanthosis, and loss of granular layer, papillomatosis, microabscess, dermal vasculature proliferation and increased mitosis up to 50 fold. Signs of lichen planus are hyperkeratosis, hypergranulosis (wedge-shaped), irregular epidermal hyperplasia (saw tooth appearance), a band like a lymphocyte infiltration, Civatte bodies, basal cell degeneration (vacuolar) [4]. Both of psoriasis and lichen planus shows Koebnerisation [5].

Lichen simplex chronic

This disease shows dry and itchy oval plaques and resembles psoriasis as a shape but not have silvery scales Auspitz and candle signs. And shows violaceous tint.

Pityriasis alba shows a white plaque, like psoriasis but have not an erythema. It has been seen only face [3,6,7].

Syphilis secondary period symptoms resemble psoriasis sometimes and called as psoriasiform plaques. Exact diagnosis should be done by serological tests for syphilis.

Tinea pedis sometimes resembles psoriasis but psoriatic plaques are characterized by infiltrated erythema and generally hyperkeratotic and extended from heels to ankles [4]. Diagnosis of tinea pedis should be done by mycologic tests. Psoriasis never shows central healing in the middle of the plaque [5].

Allergic contact dermatitis generally occurs on the hands. Acute phase signs vesicules and itching; chronic phase signs resemble psoriasis and dry, itchy erythema and squares. This square doesn't show candle and Auspitz signs. Erythema is not infiltrating [3-5]. If chronic hand eczema is a disease difficult to diagnose IL-36alpha may be helpful [7]. Dermoscopy of the hand lesions may be helpful. White scales were significant in palmar psoriasis whereas the presence of yellowish scales, brownish-orange dots/globules, and yellowish-orange crusts was significant in chronic hand eczema [8].

Diaper dermatitis shows erythema sometimes erosions on napkin area but psoriasis shows infiltrating erythema never involves flexural creases [3,4,6].

Atopic dermatitis shows erythema and dry squares especially involves antecubital and popliteal fossae, retro-auricular regions, scalp, face, extensor surfaces of the limbs. Diagnosis should be made by Hanifin-Rajka or UK working party diagnostic criteria. Sometimes serum Ig E levels may be high [4]. Both of atopic dermatitis and psoriasis have a positive family history up to 40 %. Atopic dermatitis may be associated with asthma, hay fever, urticaria [5], gastroenteritis, conjunctivitis [4,9].

All Diseases including Differential Diagnosis of Psoriasis

- Akut blepharitis

- Allergic contact dermatitis
- Atopic dermatitis
- Atopic keratoconjunctivitis
- Cutaneous squamous cell carcinoma
- Diaper dermatitis
- Dry eye syndrome
- Gout, pseudogout
- Lichen planus
- Lichen simplex chronicus
- Mycosis fungoides
- Nummular dermatitis
- Onychomycosis
- Pityriasis alba
- Pityriasis rosea
- Pustular eruptions
- Reactive arthritis
- Seborrheic dermatitis
- Sicca keratoconjunctivitis
- Subcorneal pustulosis
- Syphilis
- Tinea [5]

References

1. Lui H (2016) Plaque psoriasis: Practise essentials, overview, pathophysiology. Medscape.
2. Pinton PC (2013) Psoriasis differential diagnosis. 2: 66.
3. (2016) Psoriasis best practise.
4. Tüzün B, Tüzün Y (1998) Psoriasis dipnotları. Nobel Tıp Kitabevleri, İstanbul.
5. (2009) Differential diagnosis of psoriasis.
6. Meffert J (2016) Psoriasis differential diagnosis. Medscape.
7. Schiattarello M, Patrino C, Balato N (2016) Chronic hand eczema, a disease difficult to diagnose and classify: Is IL-36 alpha helpful? G Ital Dermatol Venereol 4: 42.
8. Errichetti E, Stinco G (2016) Dermoscopy in differential diagnosis of palmar psoriasis and chronic hand eczema J Dermatol 43: 423-425.
9. Sigfried EC, Hebert AA (2015) Diagnosis of atopic dermatitis: Mimics, overlaps and complications 4: 884-917.