An old man with desquamative extensor skin lesions and periorbital changes

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A 62-year-old male patient presenting with schizophrenia, arterial hypertension, and non-dialysable renal failure was referred to our service because of acute urinary infection. He was chronically using amlodipine, quetiapine, clonazepan, and levopromazine. Since a young age, he had undergone dermatological evaluations, including skin biopsies, because of recurrent episodes of desquamative plaques over the skin of extensor regions. There was no evidence of joint involvement nor any classical nail deformities, and he had often used oral or topical corticosteroids to control the cutaneous lesions. During the last two years, he claimed pruritus on the eyelids and periorbital areas. On admission, he was obese, hypertensive, without lymph node enlargements or visceromegaly; and presented with an ocular mucopurulent discharge, erythematous changes and inspissations of the eyelids. Ophthalmologic evaluation detected blepharitis and keratoconjunctivitis, and ruled out pterygium, pinguecula, uveitis, cataracts and glaucoma; but moderate retinal vascular changes of arterial hypertension were found. Multiple scaling plaques were observed on the buttocks, elbows, ankles, and distal interphalangeal joints, in addition to crops of ruptured vesicles in the plantar area. Laboratory data confirmed a diagnoses of bacterial conjunctivitis and urinary infection, and these were well controlled with moxifloxacin eye drops, and intravenous ceftriaxone. He was then discharged to outpatient surveillance at Dermatology and Ophthalmology.

What is your diagnosis?
ANSWER to PHOTO QUIZ

Psoriasis in plaques with eyelid involvement

Periorbital dermatitis is a frequent condition that often poses diagnostic challenges [1]. The most common causes are different types of contact dermatitis and atopic eczema, whereas rosacea and allergic eczema are infrequent, and psoriasis vulgaris is rare [1,2]. This 62-year-old Brazilian man with antecedent of schizophrenia and arterial hypertension presented psoriatic plaques concomitant with ocular involvement. Diagnosis of psoriasis was previously established in another hospital, based on clinical data and histopathological findings, and the adherence to treatment had always been very poor, mainly because of his mental status. He had never utilized methotrexate, non-steroidal or antimalarial drugs, or TNF-α inhibitors. Moreover, due to inadequate hygiene habits, he usually scratched his eyelids with unwashed fingers and dirty nails, an action that encourages bacterial infections on the conjunctiva. It is worth noting that his ophthalmological evaluation did not fulfill criteria for Sjögren syndrome [3]. Psoriasis is a chronic inflammatory entity, affecting up to 3% of the general population, and different types of cutaneous lesions and arthritis are the most common features [3]. Patients with psoriasis have increased morbidity and mortality, due to higher incidence of obesity, diabetes, and cardiovascular diseases [4] and the inflammation is associated with elevated levels of C-reactive protein, TNF-α, interleukins and homocysteine [3,4]. Diverse ocular changes affecting the conjunctiva, cornea, sclera, uveal tract and lens have been described in patients with psoriatic osteoarthritis, under treatment or not [3]. A recent cross-sectional study of eye diseases in 40 Brazilian patients with psoriatic arthritis showed a mean age of 53.9 ± 13.1 years, 40% males, 42.5% hypertensive, mean duration of disease of 8 ± 10.5 years, and 42.5% were utilizing oral corticosteroids [3]. In a study of 100 Asian patients with plaque-type psoriasis, 63 had cataracts, 2 had uveitis, and 2 had glaucoma; the authors concluded that eye disorders are common findings [5]. Nevertheless, ocular complications of psoriasis can be misdiagnosed and underreported, because signs and symptoms may be missed or mistaken by more frequent conditions [6]; therefore, primary care physicians and specialists must be aware of this possibility [6]. Considering that drugs may be precipitant factors for worsening of lesions in patients affected by psoriasis, [3,4] additional concern in the present case might be about current use of amlodipine [7]. However, the Naranjo adverse drug reaction probability scale score did not indicate that the association between drug use and worsening of the psoriasis was probable in this patient. Actually, non-steroidal anti-inflammatory drug (NSAID)s, beta-blockers, lithium, antimalarials, and gold can play a major role. Although ocular complications of psoriasis are not uncommon, the relevant data in the literature have been scarce. Therefore, this relevant clinical condition seems to be under-diagnosed and under-reported, deserving more attention in daily practice and further prospective research.

References