

Pityriasis Amiantacea: Brief Literature Review and Practical Experience

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Short Communication

Pityriasis Amiantacea (PA) can be understood as an intense inflammatory reaction pattern that affects the scalp, secondary to different dermatoses that usually evolve this region [1]. Described by Alibert in 1832, it is characterized by the presence of thick silvery scales, strongly adhered to tufts of hair. The scales are arranged in an overlapping manner like flakes of asbestos, justifying its name amiantaceus [1,2]. Genetically predisposed patients, suffering from some kind of scalp dermatoses, when submitted to determine environmental factors like poor hygiene and secondary superficial infection can develop PA. Although primary trigger of this reaction pattern is still unknown, making the complete etiopathogenesis unclear [3].

Epidemiologic data are scarce, being hard to determine incidence or prevalence. It can occur at any age, but it seems to be more common in children. A female predominance is reported also [3,4]. Seborrheic dermatitis, psoriasis and tinea capitis are the main underlying conditions, but atopic dermatitis, Darier disease and even as an adverse effect of tumour necrosis factor-alpha inhibitor therapy were also reported [4-7]. Clinically the crusts are flattened, silver, firmly attached to the scalp, enveloping a tuft of several hairs. When removed, many hairs come out very easily along with the crust. The exposed skin surface is erythematous, sometimes with a purulent exudate. In general, a few plaques can be identified, most commonly on parietal region, although in severe cases the entire scalp can be involved. Non-scarring alopecia usually follows the clinical findings but in rare cases, of long evolution and poor therapeutic response, scarring alopecia may occur [3,4]. Syndromic diagnosis of PA can be made on clinical bases, since clinical exam is very characteristic. Dermoscopy can be useful to complement clinical exam, since it magnifies the clinical features and demonstrates the correlation of the scales with the asbestos fibers [1,8]. The propaedeutic sequence is directed to the diagnosis of the underlying condition. Dermoscopy itself can be a great tool, since patterns to tinea, seborrheic dermatitis and psoriasis were already described [9]. It is imperative that the mycological examination of scales and hair shafts be performed, aiming to confirm or exclude tinea capitis. Some authors speculate that the overgrowth of *Staphylococcus aureus* in the scalpate

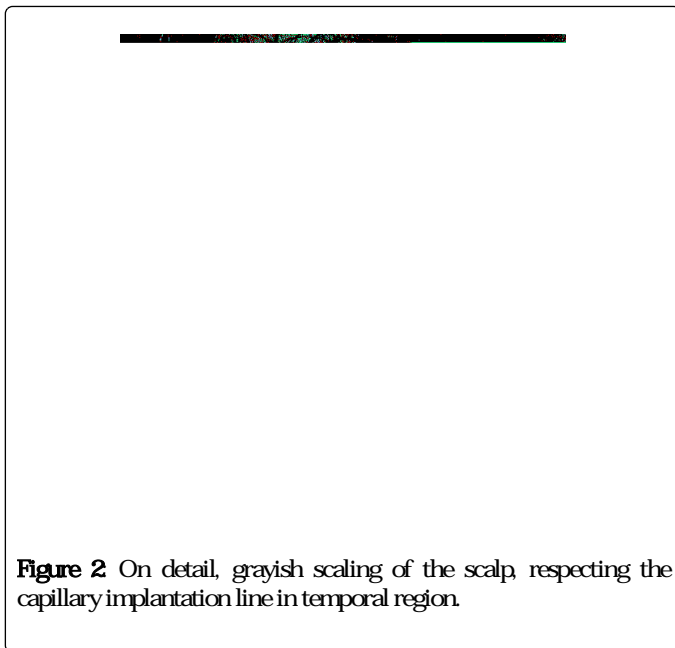


Figure 2 On detail, grayish scaling of the scalp, respecting the capillary implantation line in temporal region.

Since it was first described in 1832, little new information has been published about the epidemiology and pathophysiology of PA. With this letter approaching this subject, we seek to draw attention to the recognition of this condition.

References

1. Fitzpatrick TB, Wolf K, Goldsmith LA, Katz SI, Gilchrest BA, et al. (2008) *Dermatology in general medicine*. 7th (ed). New York: McGraw-Hill Medical.
2. Moon CM, Schissel DJ (1999) Pityriasis amiantacea. *Cutis* 63: 169-170.
3. Gupta LK, Khare AK, Masatkar V, Mittal A (2014) Pityriasis amiantacea. *Indian Dermatol Online J* 5: S63-S64.
4. Abdel-Hamid IA, Agha AS, Moustafa YM, El-Labban AM (2009) Pityriasis amiantacea: A clinical and etiopathologic study of 85 patients. *Int J Dermatol* 42: 260-264.
5. Ginarte M, Pereiro J: M, Fernández-Redondo V, Toribio J (2000) Pityriasis amiantacea as manifestation of tinea capitis due to *microsporum canis*. *Mycosis* 43: 93-96.
6. Hussain W, Coulson IH, Salman WD (2009) Pityriasis amiantacea as the sole manifestation of Darier's disease. *Clin Exp Dermatol* 34: 554-556.
7. Ettl J, Wetter DA, Pittelkow MR (2012) Pityriasis amiantacea: A distinctive presentation of psoriasis associated with tumour necrosis factor-alpha inhibitor therapy. *Clin Exp Dermatol* 37: 639-641.
8. Verardino GC, Macedo PM, Azulay-Abulafia L, Jeunon T (2012) Pityriasis amiantacea: Clinical-dermatoscopic features and microscopy of hairs. *Na Bras Dermatol* 87: 142-145.
9. Lallas A, Kyrgidis A, Tzellos TG, Apalla Z, Karatolias A, et al. (2012) Accuracy of dermoscopic criteria for the diagnosis of psoriasis, dermatitis, lichen planus and pityriasis rosea. *Br J Dermatol* 166: 1198-1205.
10. Amorim GM, Fernandes NC (2016) Pityriasis amiantacea: A study of seven cases. *An Bras Dermatol* 91: 694-696.