Pityriais Amiantacea: Brief Literature Review and Pratical Experience

Gustavo Moreira Amorim[1,2*], **Dâmia Leal Vendramini Amorim**[2], **Eduardo Mastrangelo Marinho Falcão**[1,3] **and Nurimar Conceição Fernandes**[1]

[1]*Federal University of Rio de Janeiro, Rio de Janeiro, Brazil*

[2]*Institute of Dermatology Professor Rubem David Azulay, Rua Santa Luzia, Rio de Janeiro, Brazil*

[3]*Institute Oswaldo Cruz, Manguinhos, Rio de Janeiro, Brazil*

[*]**Corresponding author:** Gustavo Moreira Amorim, Federal University of Rio de Janeiro, Rio de Janeiro, Brazil, Tel: +55 21 39382580; E-mail: gustavomoreiraamorim@hotmail.com

Received date: April 25, 2017; **Accepted date:** June 15, 2017; **Published date:** June 17, 2017

Short Communication

Pityriasis Amiantacea (PA) can be understood as an intense inf ammatory reaction pattern that af ects the scalp, secondary to dif erent 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 tuf s of hair. T e scales are arranged in an overlapping manner like f akes of asbestos, justifying its name amiantaceus [1,2]. Genetically predisposed patients, suf ering from some kind of scalp dermatoses, when submitted to determine environmental factors like poor hygiene and secondary superf cial 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 determined 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 ef ect of tumour necrosis fator-alpha inhibitor therapy were also reported [4-7]. Clinically the crusts are f attened, silver, f rmly attached to the scalp, enveloping a tuf of several hairs. When removed, many hairs come out very easily along with the crust. T e exposed skin surface is erythematous, sometimes with a purulent exudate. In general, a few plaques can be identif ed, most commonly on parietal region, although in severe cases the entire scalp can be evolved. Non-scarring alopecia usually follow the clinical f ndings 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 magnif es the clinical features and demonstrates the correlation of the scales with the asbestos f bers [1,8]. T e 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 shaf be performed, aiming to conf rm or exclude tinea capitis. Some authors speculate that the overgrowth of staphylococcus aureus in the scalpate e µ" fi ʂta ˎ ̒ ̒ ietimes%l"t ᵠl

dʒ ɿʊɿ ɓ ž ʽ

aξead! lMł Eώ an

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

Since it was frst 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, Gilcherest BA, et al. (2008) Dermatology in general medicine. 7th (ed). New York: Mcgraw-Hill Medical.
2. Moon CM, Schissel DJ (1999) Pityriais amiantácea. Cutis 63: 169-170.
3. Gupta LK, Khare AK, Masatkar V, Mittal A (2014) Pityriasis amiantácea. Indian Dermatol Online J 5: S63-S64.
4. Abdel-Hamid IA, Agha AS, Moustafa YM, El-Labban AM (2003) Pityriasis amiantacea: A clinical and etiopathologic study of 85 patients. Int J Dermatol 42: 260-264.
5. Ginarte M, Pereiro Jr. 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 amiantácea as the sole manifestation of Darier´s disease. Clin Exp Dermatol 34: 554-556.
7. Ettler J, Wetter DA, Pittelkow MR (2012) Pityriaisis amiantacea: A distinctive presentation of psoriasis associated with tumour necrosis fator-alpha inhibitor therapy. Clin Exp Dermatol 37: 639-641.
8. Verardino GC, Macedo PM, Azulay-Abulafa L, Jeunon T (2012) Pityriasis amiantacea: Clinical-dermatoscopic features and microscopy of hais tufs. 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, dermatites, lichen planus and pityriais rósea. Br J Dermatol 166: 1198-1205.
10. Amorim GM, Fernandes NC (2016) Pityriais amiantacea: A study of seven cases. An Bras Dermatol 91: 694-696.