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SUBCORNEAL PUSTULAR DERMATOSIS

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Summary

A case of Subcorneal pustular dermatosis is reported with generalised lesions in an adult male.

Subcorneal pustular dermatosis (SPD) is a chronic disease first described by Snedden & Wilkinson[1] in 1956. It shows pustules in annular and serpigenous arrangement especially on the abdomen, axillae and groins. It commonly affects middle aged women and the male female ratio is about 1 : 4. Since its description as a separate entity, more than 140 cases have been described, some of them seen also in younger age group. The average age of occurrence of this disease is between 40–50 years. It was distinguished from three other conditions viz., impetigo bullosa, impetigo herpetiformis and dermatitis herpetiformis. However at the present time, there is insufficient evidence to prove that subcorneal pustular dermatosis (SPD) is a variant of dermatitis herpetiformis or as has been suggested a separate entity. A case has been reported below, who showed unusual features of SPD.

Case Report

A 25 year old male patient presented with complaints of recurrent attacks of pustular lesions for 5 years. He was treated by many doctors and received different antibiotics and cortico steroids without any relief. On examination, multiple vesiculo-pustules were seen on the front of the chest, back, abdomen, neck, face, arms, thighs and legs including dorsum of the feet. (Fig. No. 1 Page No. 220) Several areas of crusting and hyperpigmentation were noted which were of annular and serpigenous varieties. In some lesions characteristic pustules and hypopigmented patches were evident. Mucous membranes were normal. The lesions were symptomless. Systemic examination did not show any abnormalities.

Repeated cultures from the pustule did not show any organism. Routine blood tests were normal and Tzanck test negative. Histopathology showed subcorneal vesicle with preponderence of neutrophils. (Fig. No. 2 Page No. 220) No evidence of acantholysis was noted. There was a mild perivascular infiltrate. The findings were diagnostic of SPD.

The patient was hospitalised and 200 mgs. of DDS was given daily and without any antibiotic therapy all the lesions healed well in about 8 days' time. He was then advised a daily maintenance dose of 100 mgs. DDS.

Discussion

SPD is a very uncommon condition, only a few reports having appeared in the Indian literature. Mathur NK[2]

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et al and Singh RP[3] reported cases of SPD in young adult males. The clinical picture and histological findings are as a rule sufficient enough to differentiate it from Bullous impetigo, Pemphigus foliaceous and pustular psoriasis. In our patient pemphigus foliaceous seemed a possible diagnosis. However the lack of response to corticosteroid therapy, quicker response to DDS and the histological features were against this diagnosis. Our patient showed unusual features such as extensive facial involvement and younger age of incidence.

Nothing definite is known regarding the etiology of SPD. The possibility of this being due to pyogenic organisms can be ruled out by the fact that cultures have been repeatedly negative. Pagnes[4] presumed virus to be the causative agent. The response to DDS suggests resemblance to Dermatitis herpetiformis and Peterson et al[5] have shown a rise of β-2 and $\pounds$ globulin fraction in both these conditions.

However unlike Dermatitis herpetiformis, treatment with DDS can often be stopped without a relapse. Steroids are less effective even in large doses and antibiotics are valueless.

Whatever be the aeteological factors of SPD, there are many features like absence of itching, remissions without any specific treatment and histological features to distinguish it from Dermatitis herpetiformis.

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