PRIMARY MACULAR ATROPHY

(A Case report of anetoderma of Jadassohn-Pellizari)

By

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Primary macular atrophies or anetodermas have been subdivided on morphological grounds into (1) Anetoderma of Jadassohn–Pellizari–macular atrophy with preceding erythema or urticaria and (2) Anetoderma of Schweninger–Buzzi–macular atrophy not preceded by clinically evident inflammatory changes and (3) Varioliform atrophy. Intermediate forms between the syndromes of Jadassohn and of Pellizari suggests that they are essentially similar, and many authorities now believe them to be identical. Some cases of blepharochalasis and other forms of cutis laxa are probably closely related and may be another form of the same syndrome1–7. The rare Schweninger – Buzzi anetoderma is clinically distinctive and separately classified 8–11.

Macular atrophies are characterised histologically by an acquired deficiency of dermal connective tissue and clinically by circumscribed areas of thin, soft & finely wrinkled skin. Primary atrophies differ from secondary atrophies, only in that the latter are associated with an identifiable disease process. In fact the dividing line between "Primary" and "Secondary" forms is founded more on ignorance. [1]

Case Report: A male patient – C. S. Shetty – aged 27 years attended the out-patient department of the Nair Hospital, Bombay, with complaints of small raised skin lesions on the neck, trunk & back for the last 2 years.

Origin – duration – progress: 2 years ago, patient noticed a single red patch of $1\frac{1}{2}''$ in diameter over the right lateral side of the chest. There was no itching over the lesion, later on he noticed similar raised reddish patches cropping up, over the left side of the chest, back and subsequently over the neck. These patches come up insidiously with no pruritus, for which the patient came to the hospital for specialised attention

Family history: no history of similar lesions in the family. Past and personal history – Patient has been in good health, average built and nourished.

General Examination & systemic Examination – no evidence of any septic foci – dental or E. N. T. and systemic examination – Normal. Patient has not found the need for taking any drugs and has not needed any medical attention for the last 4 years.

Local Examination: showed crops of round and oval macular lesions of varying sizes over the back and over the sides of the chest on close examination

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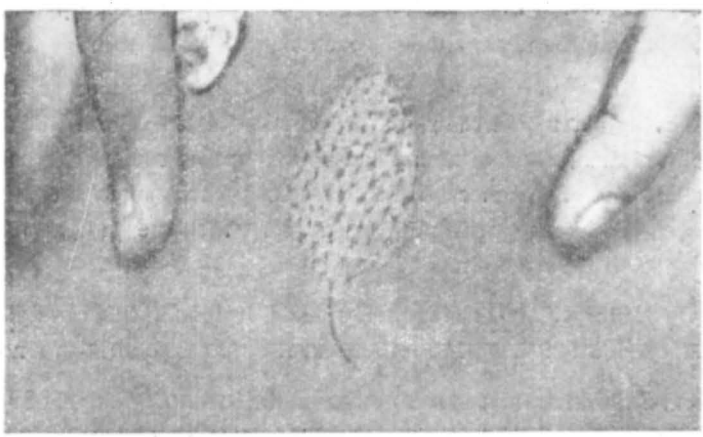
(Fig. 3.)

(Fig. 4.)



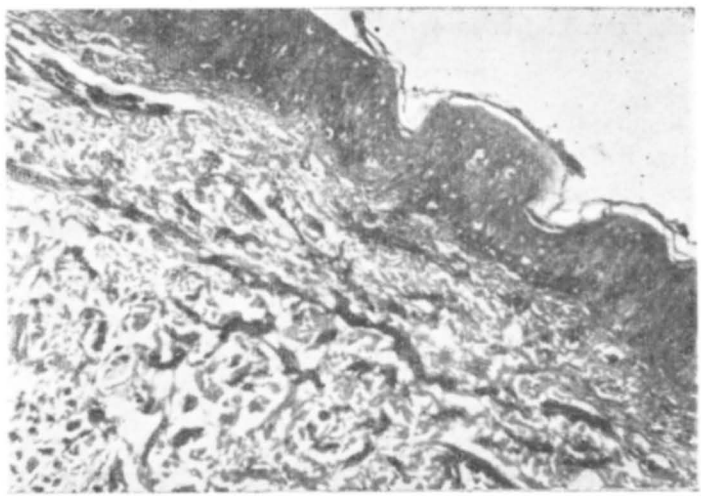
of an individual lesion the macules appeared thin, soft and wrinkled, atrophic, yielding to pressure, a finger tip palpation, yielded through the surrounding ring of normal skin. The lesions appeared unchanged for the last 2 years. The early lesions on the neck and upper arms showed a pinkish hue (erythema)

Investigations :— Routine Haemotological counts - normal. Bl. V. D. R. L. negative. Urine, Stool & sputum Ex - normal. X-Ray chest - Normal. L. E. cell phenomena - ve.

Skin snip for lepra bacilli – negative.

Skin Biopsy – (Fig. 5). The epidermis is thinned out with atrophy of the stratum malphigi. The dermal collagen and elastic tissue shows fragmentation & disappearence of elastic tissue, more marked in the sub-papillary region extending downwards in the dermis.

(Fig. 5.)



Treatment :— Patient was given Inj. Penidure L. A. 6 lac twice weekly for a total of 6 inj. (3 weeks) on the assumption that this entity is of an inflammatory nature. It was our opinion that the course of the disease was uninfluenced by the therapy.

Discussion. "Primary macular strophies" differ from "secondary atrophies" in that the latter are associated with an indentifiable disease process. The case presented we believe is a variant of Anetoderma of Jadassohn-Pellizari. This case was a male patient though women have been reported more commonly. [1] It is possible that this entity is a pattern of reaction rather than an aetiological entity. The infective theory hold in cases associated with acrodermatitis atrophicans and the response of the early inflammatory stage to penicillin. The preceding erythema or urticaria morphologically serves to differentiate this entity from Anetoderma of Schweinger-Buzzi 8–11. Atrophoderma of Pasini & Pierini is another entity that may come in the differential diagnosis, but this entity follows or precedes morphoea or may be congenital. Other secondary macular atrophies should be excluded like syphilis, lupus erythematosus acrodermatitis chronica atrophicans and other inflammatory diseases.

Summary (1) Primary macular atrophies are rare skin entities. A case of Anetoderma of Jadassohn-Pellizari is presented. This case we believe is the first case reported in India.

(2) The case was a male patient, though women have been reported more commonly.

(3) On the assumption that this entity is of an inflammatory nature, a course of long acting Pencillin (Penidure LA) was given to the patient for a period of 3 weeks. It was our opinion the course of the disease was uninfluenced by the therapy.

(4) A search for any secondary factors that may have been responsible for the atrophy proved infructious

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