PEDIATRIC ROUNDS

PITYRIASIS ALBA

Deepak A Parikh

Pityriasis alba, a non- specific dermatitis, has been regarded as a manifestation of atopic dermatitis though not always confined to atopics.

Pityriasis alba is commonly seen in children between the ages of 3 and 16. Both the sexes are equally susceptible. Initial individual lesions are round or oval, pink or skin-coloured with fine lamellar scaling. Later when the erythema subsides and scales desquamate, it shows as hypo to depigmented macules. Most of the time patient consults physician around this time, where differential diagnosis of indeterminate leprosy and tinea versicolor becomes mandatory.

Skin lesions are multiple, range from 0.5 to 2 cm in diameter. They are most common around the mouth, chin and cheeks. However, it can also be seen on the neck, arms and shoulders. At times scattered lesions are present on the trunk and limbs with sparing of the face. Recurrent crops of new lesions may develop at intervals.

Microscopic features are most of the time non-specific. Vargas[1] studied biopsy specimen of 39 patients. He suggested that a histopathological diagnosis of pityriasis alba may be proposed when the following features are seen in a biopsy specimen,

1) Irregular pigmentation by melanin of the basal layer.
2) Follicular plugging
3) Follicular spongiosis
4) Atrophic sebaceous glands.

Du- Toit et al[2] reported unusual presentation of pigmenting pityriasis alba. Their patients had a central zone of bluish hyperpigmentation surrounded by a hypopigmented, slightly scaly halo of variable width. They treated patients with 10 mg/ kg/ day of griseofulvin for eight weeks and 1 % hydrocortisone with good response.

They concluded that pigmenting pityriasis alba has strong association with dermatophytic infection especially tinea capitis.

Pityriasis alba needs to be differentiated from indeterminate leprosy, as both tend to appear on face, where to elicit sensory changes is difficult. Indeterminate leprosy has one to four lesions, bilateral and asymmetrical. Wolf et el [3] have reported 3 patients of pityriasis alba mistaken for psoriasis. Witmore et al[4] reported three patients of hypopigmented mycosis fungoides which were initially diagnosed and treated for pityriasis alba.

Treatment of pityriasis alba is unsatisfactory, starting from bland emollient creams to tar to topical corticosteroids. The lesions repigment within 2 to 3 weeks of treatment with low- potency topical corticosteroid, followed by sun exposure. It is prudent not to use class II-IV topical steroids. However it may take several months to disappear and parents should be reassured that complete repigmentation will eventually occur.

References

1) Vargas - Ocampo-F. Pityriasis alba : a histologic study. Int J Dermatol 1993 : 32; 870 - 873.

2) Du- Toit - MJ, Jordan HF. Pigmenting pityriasis alba. Pediatric Dermatol 1993; 10: 1-5.

3) Wolf R, Wolf D , Tran H. Pityriasis alba in a psoriatic location. Acta Derm Venereol (Stockh) 1992: 72; 360.

4) Whitmore SE, Simmons O E, Rotter FS. Hypopigmented mycosis fungoides. Arch Dermatol 1994 : 130; 47- 48.