

## A Psoriasis Case With Different Clinical Forms

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### ABSTRACT

Psoriasis, inflammatory skin disease with increased epidermal proliferation is usually characterized by erythematous lesions with silvery scale. In addition to classical plaque psoriasis, there are different forms of psoriasis like erythrodermic psoriasis, generalized pustular psoriasis and psoriatic arthritis. Although bromocriptine is an agent that can be used in the treatment of psoriasis, it aggravated the lesions of our patient. This case was presented due to presence of three types of psoriasis and aggravation by bromocriptine.

**Key words:** psoriasis, atypical forms, bromocriptine

### Psoriasisın Farklı Klinik Tiplerinin Bir Arada İzlendiği Olgu

### ÖZET

Psoriasis, epidermal proliferasyonda artışla birlikte eritemli zeminde gümüş rengi kepeklerle kaplı lezyonlarla karakterize inflamatuvar bir deri hastalığıdır. Klasik plak tip psoriasis ek olarak psoriasisin eritrodermik psoriasis, jeneralize püstüler psoriasis ve psoriatik artirit gibi farklı formları vardır. Bromokriptin, psoriasis tedavisinde kullanılabilir bir ajan olmasına rağmen, bizim hastamızın lezyonlarını alevlendirmiştir. Bu vaka, psoriasisin üç tipinin bir arada olması ve bromokriptinle lezyonların alevlenmesi yüzünden sunulmuştur.

**Anahtar kelimeler:** psoriasis, atipik formlar, bromokriptin

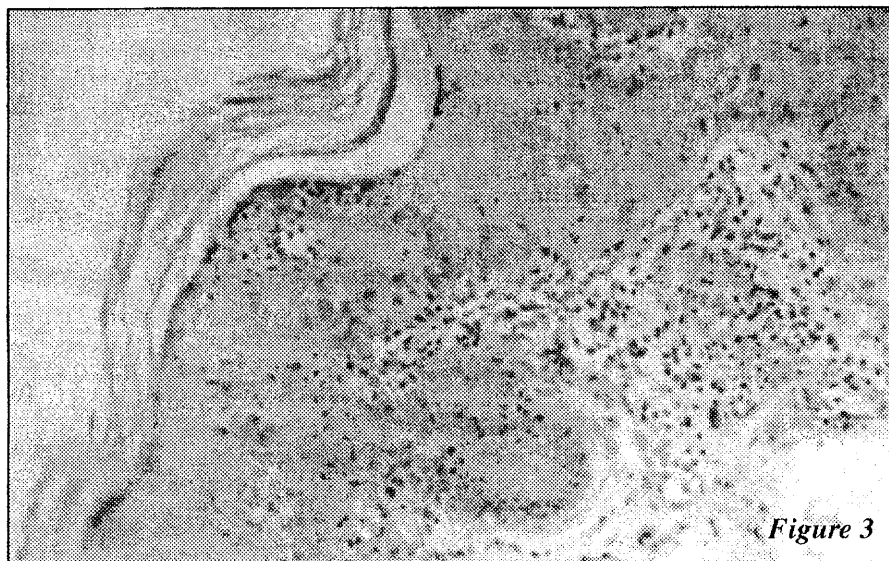
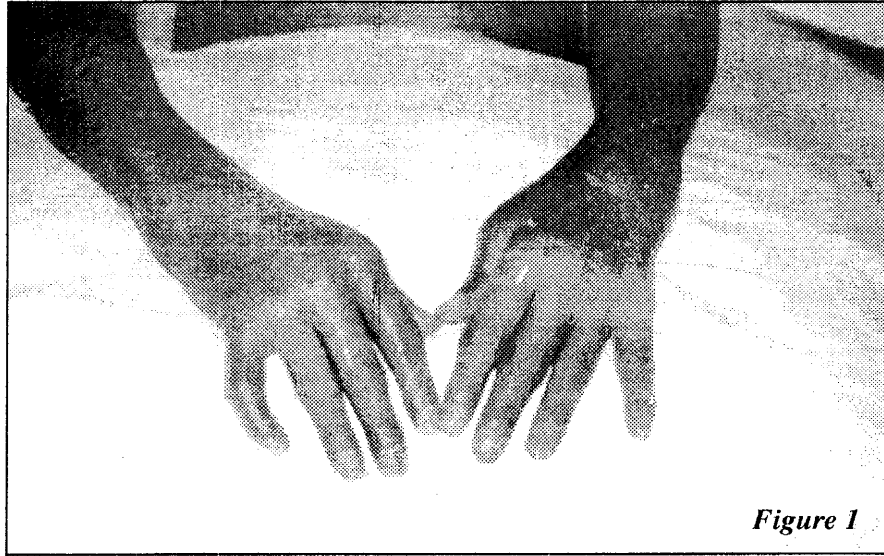
30 years old woman had applied to our clinic because of erythema and desquamation of whole body surface. Her complaints had began 8 months ago with erythema and small pustulas on her body when she was pregnant for 7 months. Furthermore, she complained about the deformity and function loss of her hand fingers and wrists that occured after she gave birth. Her aunt had psoriasis vulgaris.

In physical examination, ulnar deviation and roughing of wrists and metacarpophalangeal joints, contracture of hand and foot fingers were attracting attention (Figure 1). Except these, her all systemic examination was normal. In her dermatologic examination, there was thick grey squam and erythema on scalp, earlaps, face, body and extremities. Thickening and pitting of her hand and foot nail were attracting attention.

Her laboratuary analysis were normal except anemia (Hb:11.7 g/dl), hypocalcemia (Ca:7.6 mg/dl), hyperglisemia, low total protein (5.8g/dl), high erythrocyte sedimentation rate (57 mm/h) and hyperprolactinemia.

Oral steroid was began to the patient who was thought to be erythrodermic psoriasis and hospitalized.

She also had taken methotrexate because of psoriatic arthritis and the dose of oral steroid was decreased slowly. And bromocriptine had began because of hyperprolactinemia. After using bromocriptine for two days, erythematous and pustular lesions developed on her neck, forehead, dorsum of hands and fouts, and then there was a transition to generalized pustular psoriasis (Figure 2). In histopathologic examination of biopsy specimen, there were hyperkeratosis, loss of granular layer, pustulas formation in epidermis and mononuclear infiltration in papillary dermis (Figure 3).



## Discussion

Psoriasis is a chronic skin disease that is classically characterized by thickened, red areas of skin covered with silvery scales(1,2). Psoriasis affects 1% to 2% of general population (1-3). It has no known cure and can affect all age groups. In addition to classical plaque psoriasis a severe inflammatory form of the disease erythrodermic psoriasis or generalized pustular psoriasis (GPP) may produce involvement of the total body surface and may have associated systemic or constitutional manifestations(1)

Erythrodermic and GPP may be life-threatening because of systemic infections, cardiovascular or pulmonary complications (1,2,4). GPP is rare, potentially fatal, acute, sub-acute or occasionally chronic sterile pustular eruption (3). Precipitating factors influencing both local and generalized forms include various drugs (eg. Lithium, hydrochloroquine), irritative topical therapy (eg, coal tar), dental and upper respiratory infections, pregnancy and solar irradiation (5).

Methotrexate is an effective antipsoriatic agent. It is especially useful in acute GPP, psoriatic erythroderma, psoriatic arthritis and for extensive chronic plaque psoriasis in patients who are inadequately controlled by topical therapy alone(6,7). We began methotrexate to our patient because of her erythrodermic psoriasis, psoriatic arthritis and GPP. The most side-effect is acute myelosuppression which is the cause of most of the rare deaths attributable to this therapy for psoriasis. Myelosuppression is more likely seen in the elderly patients and may be a sign of methotrexate overdose. In this case a folinic acid rescue should be performed preferably within the first four hours. As methotrexate is excreted mainly with the kidneys, patients with a history of kidney dysfunction should not be treated with methotrexate. Longterm therapy carries with it a risk of liver fibrosis which is related to the dosage regimen employed (6).

Prolactin is a polypeptide hormone of anterior pituitary origin with well known effects on lactation and reproductive organs. In recent years, it has become apparent that prolactin may influence both humoral and the cell-mediated immun reactions and may play an important part in the expression of autoimmune disease (8). Bromocriptine a dopamine agonist that suppresses the secretion of prolactin by pituitary can be useful in the treatment of psoriasis vulgaris, psoriatic arthritis with a marked improvement in the lesions (8-10). However, GPP developed in our patient in second day of bromocriptine use. In according to our knowledge it has not reported GPP which was aggravated by bromocriptine.

This case was decided to present due to presence of three types of psoriasis and aggravation by bromocriptine.

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