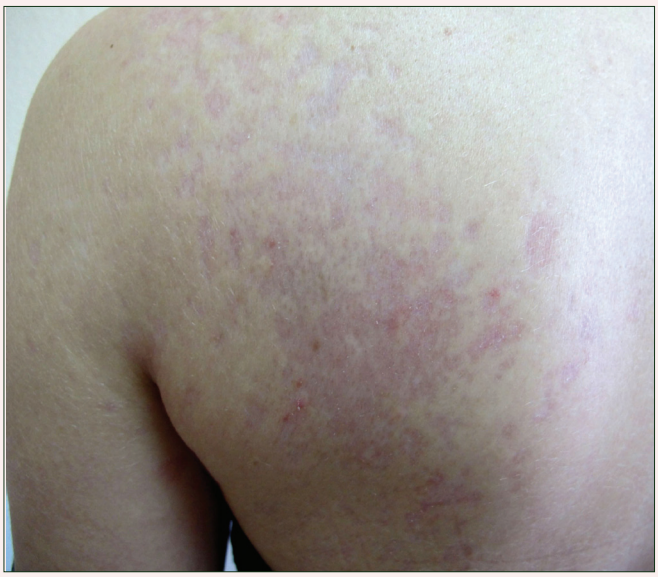
Atrophic Plaques on the Back

What's the diagnosis?



A 41-year-old woman presented with recurrent skin color and violaceous atrophic plaques that were slightly depressed and symmetrically distributed on the back and upper extremities. She had been given oral azithromycin for 3 days without improvement. Laboratory tests, including IgE levels, were within reference range. Her medical history was unremarkable.

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The authors report no conflict of interest.
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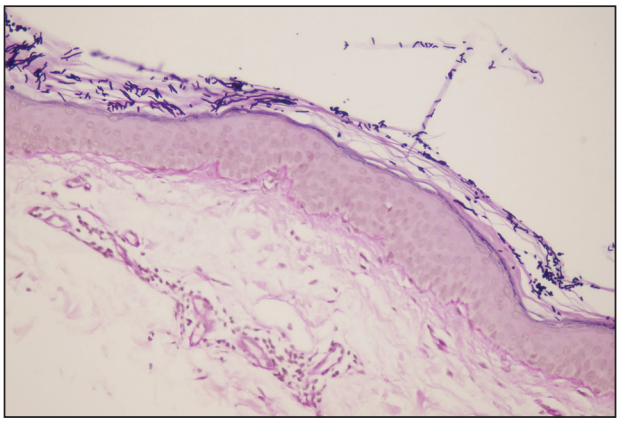
The Diagnosis: Atrophic Pityriasis Versicolor

Pityriasis versicolor lesions accompanied by skin atrophy were first reported by De Graciansky and Mery[1] in 1971. Since then, few reports have been described and it remains a rare condition.[2-5] It manifests with oval to round, ivory-colored lesions with a typically depressed and sometimes finely pleated surface.[3] The pathogenesis of the skin atrophy remains controversial. In some of the cases described, the onset of atrophy was related to long-term use of topical steroids.[1] This fact as well as impaired barrier function due to fungal infection may explain the atrophy occurring only in the pityriasis versicolor lesions.[2,6,7] Some authors call this disease "pityriasis versicolor pseudoatrophicans."[7] However, case reports have been described without use of topical corticosteroids. Crowson and Magro[8] maintained that skin atrophy in these cases may occur due to mechanisms of delayed-type hypersensitivity and coined the term *atrophying pityriasis versicolor* as a variant of this disease. Our patient did not report prior use of topical corticosteroids.

The differential diagnosis consists of other diseases that cause skin atrophy, such as collagen vascular diseases including anetoderma, morphea or atrophoderma, lupus erythematosus, dermatomyositis, and poikilodermatous T-cell dyscrasia; parapsoriasis or mycosis fungoides; sarcoidosis; cutis laxa; acrodermatitis chronica atrophicans; necrobiosis lipoidica; and atrophy due to intralesional steroid therapy.[2,3,6-8] Histologic examination helps to achieve proper diagnosis. In our patient, cutaneous biopsy showed the presence of multiple short hyphae and spores in the horny layer with hematoxylin and eosin as well as periodic acid–Schiff stains, with typical "spaghetti and meatballs" appearance. Partial atrophy of the epidermis was observed with flattening of the epidermic ridges. A comparison with the normal areas could not be made because the biopsy was taken from cutaneous lesions without areas of uninvolved skin (Figure).

Treatment of this variant does not differ from conventional therapies for pityriasis versicolor, except that a longer treatment period might be required. Atrophy usually disappears, showing that atrophic pityriasis versicolor has a relatively good prognosis compared with other diseases that cause skin atrophy.[2]



Multiple short hyphae and spores in the horny layer visible with periodic acid–Schiff staining, with typical "spaghetti and meatballs" appearance (original magnification ×20).

Our patient was treated with ketoconazole gel 2% once daily for 3 weeks with complete resolution of the lesions and no evidence of atrophy.

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