MEDICAL THERAPIES AND PHARMACOLOGY

# UNILATERAL LINEAR PIGMENTED PURPURIC DERMATOSIS TREATED WITH CLOBETASOL AND TACROLIMUS: DERMATOSCOPIC FINDINGS AND TREATMENT FOLLOW UP.

*F Reculé [1] - R Cabrera [1] - A Castro [2]*

*Facultad De Medicina Clínica Alemana-universidad Del Desarrollo, Dermatology Department, Santiago, Chile [1] - Facultad De Medicina Clínica Alemana-universidad Del Desarrollo, Pathology Department, Santiago, Chile [2]*

Background: Pigmented purpuric dermatoses (PPD) include a wide spectrum of several disorders characterized by petechial hemorrhage secondary to capillaritis with subtle inflammation and no systemic findings. Their etiology is unknown. Principal histopathologic findings are: lymphocytic capillaritis, erythrocyte extravasation and variable hemosiderosis.
Unilateral Linear pigmented purpuric dermatosis (LPPD) is a very rare PPD subtype, first reported by Riordan et al., with only thirteen cases reported until now. Its clinical distinctive features are: linear distribution, bronze macular discoloration and coppery-red pigmentation. Mainly on the lower extremities tending to persist for years with a favorable prognosis. There are 93 reports of dermatoscopic cases of PPD´s, and only one LPPD mentioned by Ozkaya et al. Dermatoscopic findings of LPPD include: coppery-red pigmentation, interconnected brown-lines, linear vessels, round-oval red dots, brown dots, gray dots, brown globules, patches and occasionally prominent follicular openings.
Herein, we report LPPD´s dermatoscopy and a new therapeutic approach.

Observation: A thirteen-year-old boy with two years of pruritic pigmented linear lesion without trauma. Physical exam: orange-brownish oval linearly arranged lesions on the left arm (Fig 1). Under dermatoscopy: dotted and glomerular vessels with an orange (hemosiderotic) background (Fig 2 a-b). The histopathology shows capillaritis and erythrocyte extravasation.
Previous treatments using low-to-medium-potency corticosteroids have failed. We indicated clobetasol 0,05% twice-daily for one month followed by tacrolimus 0,1% twice-daily for two months with good results (Fig 3 Zone A, Fig 2 c-d). Simultaneously, an adjacent area was only treated using tacrolimus (Fig 3 Zone B). Dermatoscopy showed total remission of the area treated with high-potency-corticosteroids and subsequent tacrolimus but only 30% of remission with tacrolimus alone.

Key message: Treatment is generally limited, including PUVA, narrow band UVB, topical corticosteroids and colchicine. To our knowledge this is the first LPPD treated with this

management. Future collection of new cases will provide more information.