PSORIASIS

DEVELOPMENT OF PSORIASIS WHILE RECEIVING ALLERGEN IMMUNOTHERAPY: A NEW RASH, AN OLD DEBATE, A REDHERRING

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Background: A 35-year-old woman presented with a pruritic generalized pink papular rash with overlying fine scale on her trunk and extremities and coalescing into larger plaques on her lower back, breasts and abdomen. She was nearing the end of a 10 day course of amoxicillin for streptococcal pharyngitis. The day before she was diagnosed with strep throat she had undergone subcutaneous allergen immunotherapy (AIT) for her allergic rhinitis; which she had been getting for several years. She had a history of eczema and asthma as a child. There was no personal or family history of psoriasis. Biopsy was performed and showed findings compatible with guttate psoriasis. The rash resolved after several weeks of oral and topical steroids, light therapy and topical tacrolimus ointment.

Observation: Differential diagnosis upon initial presentation included delayed hypersensitivity to amoxicillin vs. guttate psoriasis. Streptococcal infection is a common trigger for guttate psoriasis. Streptococcus is thought to activate the circulating cutaneous lymphocyte-associated antigen (CLA) positive (+) memory T cells. CLA + T cells are responsible for key mediators, including an IL-17 response. One may postulate that AIT may alter the Th1/Th2 balance towards inflammation (Th1) and this may contribute to the development of guttate psoriasis. Inflammatory cytokines play an important role in disease activity in psoriasis as well as response to AIT. In addition, mast cell degranulation has been observed to be an early finding in the evolution of guttate psoriatic lesions therefore the concern about AIT's role in development of new onset psoriasis. Despite concern for AIT facilitating development of psoriasis, she has continued to receive AIT without recurrence of her rash.

Key Message: Allergen immunotherapy in patients with psoriasis is safe and should not be stopped due to concerns for exacerbation of disease.