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Ostraceous psoriasis and psoriatic arthritis: a case report

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BACKGROUND

Background: Psoriasis is a systemic and recurrent chronic inflammatory disease, characterized by epidermal hyperplasia with keratolytic hyperproliferation and inappropriate immune stimulation, resulting from environmental and genetic factors that have not been understood yet. It affects skin, mucous, phaneros and joints. Approximately 10 to 30% of people with psoriasis develop psoriatic arthritis and this can occur in any of the clinical forms of psoriasis. The cutaneous lesions are scaly erythematous plaques, well delimited, sometimes with pruritus, located mainly in the extensor faces of the limbs, trunk, buttocks and scalp. More common in the white race, being men and women equally affected. Psoriasis hyperkeratotic lesions can be observed in the literature under several names, such as elefanthine, ostraceous, rupioid and pseudohorny. Ostraceous psoriasis should be considered when the inner face of the lesions exhibits oyster appearance and the outer surface is covered by thick and adherent scales. Most cases described in the literature are resistant to topical treatment, possibly because of the hyperkeratosis present in the lesions. There have been reports of remission of ostraceous psoriasis with immunosuppressive and biological agents.

CASE REPORT

A 69-year-old male patient, diagnosed with psoriatic arthritis since April/16, with axial and peripheral involvement (polyarticular and diffuse dactylitis). Psoriasis appeared months after arthritis, involving nail dystrophy and plaque-like lesions. Patient initially used methotrexate, without improvement, needing to associate a biological drug, etanercept. Methotrexate was discontinued due to no improvement and severe gastrointestinal intolerance. Leflunomide was associated. The disease kept in cutaneoarticular activity and, at that time, hyperkeratotic lesions also appeared. It was needed to change etanercept for adalimumab, with almost complete response on the skin until January/19. The patient stopped using adalimumab (lack in the Unified Health System supplies). Hyperkeratotic psoriasis developed again, this time more aggressive, with exuberant aspect of the lesions, similar to oysters, being diagnosed as ostraceous psoriasis, without control with TNF inhibitors. In association with psoriasis, the patient presented clinical signs of secondary infection, being treated with fluconazole 150mg/week during 8 weeks. He was instructed to use keratolytics and switched the biological by an IL12-23 inhibitor.

CONCLUSION

Ostraceous psoriasis calls attention due to the exuberance of the lesions, resistance to topical treatments and association with psoriatic arthritis. It is often unknown and rarely described in literature. So, it is necessary to show this manifestation to professionals of the area, helping the early diagnosis and appropriate treatment.