

Zosteriform Morphea: A New Pattern

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Sir,

A 21-year-old male presented with multiple brown asymptomatic plaques arranged in a zosteriform pattern, confined to the left flank of abdomen (Fig. 1) of 6 months' duration. There was no history of herpes zoster affecting the same location. His general physical and systemic examinations were within normal limits. Cutaneous examination revealed a 3–6 cm wide zosteriform band composed of brown, indurated, depressed plaques confined to the left half of the chest extending from the sternum anteriorly to the vertebral column on the back with a strict midline demarcation (Fig. 1). There was no erythema in and around the lesions. Clinical diagnosis of zosteriform morphea was made. Routine baseline investigations including complete blood cell count, ESR, clinical chemistry and urinalysis were normal. Serology for antinuclear antibodies and varicella-zoster virus was negative. Skin biopsy revealed an atrophic epidermis with flattening of rete ridges. The dermal collagen bundles were increased, thickened and hyalinized. The number of cutaneous appendages was reduced. The findings were consistent with the diagnosis of morphea. The lesions were treated with topical twice-daily application of mometasone furoate 0.1% cream. There was marked softening of the lesion within 6 months. There was no increase or appearance of new lesions during this period.

Morphea is a disorder of unknown cause characterized by localized sclerosis of the skin. The condition is subdivided clinically into the following types: circumscribed plaques or bands, linear morphea or frontoparietal lesions (*en coup de sabre*), with or without hemiatrophy of the face. Usually, the lesions appear

spontaneously, without any specific precipitating factors, but lesions have followed chickenpox, BCG vaccination, radiotherapy and injury and have developed in a hypoplastic breast (1). In the paediatric age group the linear lesions predominate, especially on the limbs; however, the zosteriform pattern of morphea has not been reported. Wakelin et al. (2) described a 53-year-old man who had a 12-year history of unilateral idiopathic atrophoderma of Pasini and Pierini (IAPP) affecting the left side of his trunk in a zosteriform distribution. Within these clinically atrophic lesions, there were localized areas of induration which were typical of morphea. Histologically, both these lesions are indistinguishable. However there were no atrophic lesions suggestive of IAPP in our patient.

The phenomenon of occurrence of a new skin disease at the site of another, unrelated, and already healed skin disease has been termed as 'isotopic response' by Wolf et al. (3). A number of skin diseases, including morphea appearing at the site of a previously healed herpes zoster, have been described (4). But there was no evidence of herpes zoster in this patient clinically or after serological investigations. A wide variety of skin diseases including lichen planus (5), porokeratosis (6), fungal infections (7), naevus (8), cutaneous malignancies (9–11) and skin metastases (12) have been reported to occur in a 'zosteriform' pattern. This term has been used to describe a dermatomal distribution of lesions as well as in cases actually resembling herpes zoster clinically (7, 10). The present case illustrates that morphea can occur in zosteriform pattern without any evidence of preceding herpes zoster.

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Fig. 1. Morphea in a zosteriform pattern on left half of the trunk.

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