

## Pityriasis Amiantacea, an Unrecognized Cause of Scarring Alopecia, Described in Four Patients

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**Pityriasis amiantacea is not generally recognized as a cause of scarring alopecia. We describe 4 patients with scarring alopecia in the distribution of past or active pityriasis amiantacea and suggest that it is a not uncommon sequela.**

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Pityriasis amiantacea (syn. tinea amiantacea, *fausse teigne amiantacée*) first described by Alibert in 1832 (1), refers to a distinctive clinical entity. The condition is characterized by thick, silvery, adherent scales which surround and bind down tufts of hair. These typical scales have been called *amiante* or *asbestos-like*, after the white or grey fibrous mineral to which they are said to bear a resemblance (2). Most commonly it is a localized condition, but may be widespread within the scalp. It may occur at any age, being more frequent in young adults, and represents a particular reaction pattern of the scalp to various inflammatory scalp diseases. These include streptococcal and fungal infections, lichen simplex, seborrheic dermatitis and psoriasis (3), and it is often misdiagnosed as the latter. The histopathology is not that of psoriasis, the features being essentially those of eczema with spongiosis and parakeratosis as the most consistent findings (2).

Scarring alopecia, the end result of destruction of hair follicles, may follow a host of pathological processes (4). Pityriasis amiantacea is not recognized as a cause. We describe 4 patients with scarring alopecia following pityriasis amiantacea.

### CASE REPORT

#### Case 1

A 7-year-old boy presented with a 6-month history of scaling at the vertex of the scalp showing the characteristic adherent scales of pityriasis amiantacea (PA). This cleared after 8 months of treatment with topical keratolytics, leaving patches of scarring alopecia in the area previously affected. Six years later, the scarring alopecia remains un-

changed. There was a past history of facial rash in infancy and both his father and paternal grandmother had 'ichthyosis', but there was no family history of psoriasis.

#### Case 2

A 24-year-old woman with a 9-year history of scalp scaling, had complained of increasing alopecia at the crown of the scalp for one year. There were typical white asbestos-like scales adherent to the scalp, running along proximal hair shafts, and a large patch of scarred alopecia at the vertex of the scalp. There was no personal history of skin disease, but her mother has psoriasis and two siblings have eczema. Scalp biopsy showed hyperkeratosis and acanthosis, a dermal chronic inflammatory cell infiltrate particularly around hair follicles associated with plasma cells and occasional foreign body giant cells. Treatment with betamethasone valerate 0.1% (Betnovate) scalp application and topical keratolytics had not relieved the condition. Prednisolone 30 mg given daily for one week, with reducing course to zero over 4 weeks, resulted in clearing of the PA. The scarred alopecia remained unchanged 9 months later.

#### Case 3

A 29-year-old woman with psoriasis since the age of 9 years, had been treated in the past with photochemotherapy, and as an in-patient on eight occasions. Scalp scaling had been a feature for several years and 2 years ago the typical appearance of PA was noted, localized to the vertex of the scalp. Topical steroids and keratolytics resulted in clearing of the PA, revealing small patches of scarred alopecia which remained unchanged one year later.

#### Case 4

A 26-year-old woman presented with a 6-year history of scaly scalp and a 6-month history of thick scales and increasing alopecia. Griseofulvin therapy for one month and topical steroids had not been of benefit. There was a past history of hand eczema and seizures for which she was taking clonazepam, phenytoin and sodium valproate. There was no personal or family history of psoriasis. Asbestos-like scales adherent to the scalp and enveloping proximal hair shafts were observed, with extensive scarring alopecia of the crown. Prednisolone 20 mg daily was given for one week in a reducing course to zero over 4 weeks with clearing of the PA. The scarred areas were unchanged 20 months later.

### DISCUSSION

Becker & Muir (5) described 3 patients with PA, and stated that the condition is not followed by atrophy, scarring or alopecia. Neurodermatitis was a common



feature in 16 patients referred to by Brown (6), but no mention of alopecia was made. The largest review is that of Knight who studied 71 patients with PA (2). Hair loss was found to be a prominent feature of the disease. This was noted in 63 patients, affecting the scaly areas and was temporary. In a follow-up study of 46 patients, in which the average observation time was 6 years, Hersle and colleagues (7) documented recurrences of PA in 6 patients. None of the patients exhibited alopecia at the site of earlier PA.

PA is a relatively common and easily recognized clinical entity. It has been observed in some 30 patients in the last 9 years in this Department. The origin is obscure in that it may be associated with diverse scalp diseases, but is most commonly an isolated entity. The accepted view of scarring alopecia is that it may follow developmental and hereditary disorders, physical injuries, infections, neoplasms and numerous dermatoses of unknown origin (4). All these conditions are now rare in childhood in this country.

Diffuse non-scarring alopecia is well known in severe scalp eczema, erythrodermic psoriasis and pustular psoriasis, with resolution as these improve. Shuster (8) recognized three types of scalp alopecia in non-erythrodermic, non-pustular psoriasis. These included hair loss confined to the lesions, acute hair fall and least commonly, scarring alopecia. Verbov described an 11-year-old boy with scarring alopecia of the scalp due to plaque psoriasis (9). Neither of these authors reported PA in their patients. The only reported cases of scarring alopecia due to PA are described by Keipert (10), namely a 2-year-old girl and a 12-year-old boy, neither with a past history of psoriasis. Most texts are agreed that whilst hair loss may occur in PA, it is temporary and will regrow. Our contrary view is that patchy permanent hair loss from scarring alopecia not uncommonly follows the condition and that in our experience, derived from these and a number of other cases seen, it is a common cause of scarring alopecia in childhood.

Our initial approach to treatment includes keratolytics and topical steroid scalp lotions or creams. Patients are advised to avoid unnecessary trauma in removing scale. If resolution of the PA is not achieved and disfiguring scarring alopecia threatens, a short course of systemic steroids is prescribed, due cognizance being paid to the potential risk of aggravation of any associated psoriasis (11).

Scarring alopecia is a serious complication of PA, leading to permanent disfigurement. This may be alleviated or avoided if the possibility is recognized early and treated energetically.

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