CASE REPORT: PRIMARY ANETODERMA

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ABSTRACT: Anetoderma is a localised laxity of skin with herniation resulting from weakened elastic tissue, the course of which is unknown. In some cases it is found to have an infective origin as they respond to penicillin. The term macular atrophy is obsolete and it is currently applied for other types of dermal atrophy. Histology shows focal elastolysis, which may be secondary to release of elastase from inflammatory cells.
KEY WORDS: Anetoderma: macular atrophy, propinobacterium acne, elastase and elastolysis.

INTRODUCTION: Anetoderma is a disease commonly missed to diagnose properly, because the lesions may mimic localised atrophic scars morphea, patches of scleroderma and small keloids. Proper diagnosis of the condition helps the dermatologist in assessing the other conditions properly and for the better treatment of other chronic diseases at the needed point which will be life saving in many situations.

CASE REPORT: A 43 year old male has presented to the OPD with oval macules and patches distributed over the shoulders, trunk, and anterior axillary area of 2 yrs duration. The lesions are asymptomatic and show wrinkling and bulged out appearance. There was no erythema or tenderness. He had tender indurated nodular lesions on the face, polyporous comedons, and hyper pigmented puckered scars and pitted scars on the face and shoulder. Routine investigations were normal. Lipid profile, STS, ELISA for HIV, Mantaux test were negative. Histological examination of the skin revealed epidermal atrophy, upper dermis showing elastic tissue and some areas showed regeneration of elastic fibres. There were perivascular and peri adenexal lymphocytic infiltrates with dermal oedema. The elastic fibers were scanty, fragmented and shortened. In some lesions it almost disappeared from sub papillary zone.

DISCUSSION: Anetoderma is commonly seen in women aged 20 to 40 years. It may affect young or older patients, rarely males. In typical form crops of round or oval pink macules develop on trunk, thighs, upper arms and less commonly face, neck and other areas. Scalp, palms and soles are always spared. Each macule takes a week or two to reach a size of 2 to 3 cms. It may be preceded by erythema and bulging, eventually lesions fade leading to flattened, atrophic, wrinkled slightly bulged out macules. The lesions remain unchanged throughout life and some new lesions continue to develop for many years. The term anetoderma (Greek-aneto=relaxed. derma=skin) was first used by JADASSOHN in 1891, the term macular atrophy is applied only to other types of focal dermal atrophy. Primary anetoderma has no underlying pathology; whereas secondary anetoderma is associated with underlying conditions. Primary is divided into Jaddssohn-Pellizary, Schweninger-Buzzi. The former type is preceded by erythema and urticaria and in the latter type there is no preceeding inflammatory lesion. Both can co exist in the same patient. In these patients the propionibacterium acnes might have acted as a chemo attractant, which produce accumulation of

polymorph and mononuclear cells which secrete elastase and staphylococcus epidermidis in the axillary and other lesions secrete the same enzyme which might have induced elastolysis. Secondary anetoderma can be precipitated following syphilis, measles, pityriasis versicolor, arthropod bite and rarely be drug induced (pencillamine). There is no specific treatment for the disease except proper management of aetiological factors.

RESULT: This case is reported for its unique presentation in a male having acniform lesions on the face and its unusual association.

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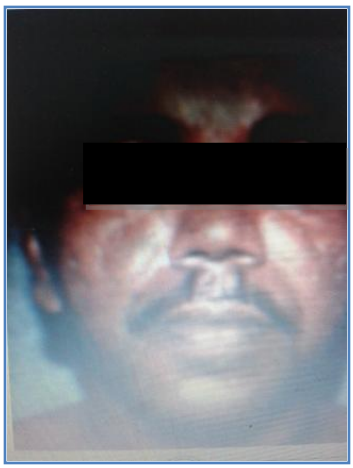
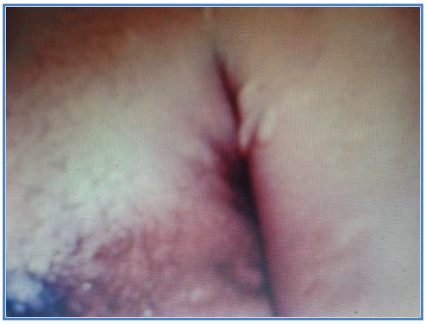


The puckered scars on the face.



Anetoderma lesions on shoulder and axillary region

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