

A Case of a Patient with Psoriasis Aggravated by Scabies Infestation

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Scabies may be seen in psoriatic patients, although not frequent. This situation provokes many problems including the difficulty of diagnosis and uncertainty of appropriate therapy. We report a case of a young female with an existing psoriasis aggravated following scabetic infestation. At first, she took an antiscabetic treatment but the severity of psoriasis persisted. Subsequently, cyclosporine treatment was started and the psoriatic lesions improved dramatically. (Ann Dermatol 14(3) 186~188, 2002).

Key Words : Psoriasis, Scabies, Cyclosporine

Psoriasis usually follows a chronic course, and can be exacerbated by various dermatoses¹. There have been a few reports of existing psoriasis aggravated by a scabetic infestation². In this case, it is likely that the combined scabetic infestation will be missed and the resultant delayed diagnosis can cause confusion concerning therapy. We report one patient with psoriasis aggravated by scabies, being worthy of note in some clinical aspects.

CASE REPORT

A 25-year-old woman presented with a 15-year history of chronic plaque psoriasis, having intermittent exacerbations and remissions. She was treated with calcipotriol at first. After 3 weeks, the lesion abruptly worsened with an itching sensation, and some potent topical steroids and starch bath were provided. Although there was a slight improvement for a short period of time, the lesion soon returned to its previous state (Fig. 1a). We

made a physical examination again and, unexpectedly, erythematous excoriated papules and disseminated scales were recognized in her hand. She had no URI symptom or sign of other febrile diseases. In routine laboratory check, only slight leukocytosis was observed. Neither itching sensation nor skin lesion was found in other members of her family. Skin scrapings from the linear scaly lesion showed numerous mites and ova. Antiscabetic treatment consisting of crotamiton cream was administered to the patient for five days and to her family for two days. The itching sensation improved slightly, but the severity and extent of psoriasis persisted. So cyclosporine was begun at a dose of 2.5 mg/kg/day along with the topical steroid and calcipotriol and the same dose continued because of the good clinical response. After 11 weeks, the lesion improved nearly completely (Fig. 1b) and the improved state has been maintained for approximately one year with calcipotriol ointment only.

DISCUSSION

In our case, it is reasonable that we consider the concomitant scabetic infestation as the main cause of the sudden aggravation of psoriasis. The mild form of psoriasis seen at initial presentation changed into a severe, active form suddenly. She had no history of trauma, drug (except calcipotriol for psoriasis) or mental stress and displayed no sign of other in-

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Fig. 1. A. Patients before treatment with cyclosporine.

B. Same patients after treatment with cyclosporine.

fection at that time. However, skin scrapings from the lesion revealed the scabietic mites and ova clearly. In addition, the itching sensation had been minimal before the time of worsening. Following the antiscabetic treatment and subsequent cyclosporine therapy, the severity and activity were controlled, and the improved state has been maintained for about one year without another episode of aggravation simply by the application of calcipotriol ointment. If there had been another precipitating factor, further attacks would have occurred.

Scabies can coexist with psoriasis in one patient, though not common. This situation often poses difficult problems to the clinicians.

First, scabies can aggravate the lesion of existing psoriasis. The exact cause of exacerbation is not yet known. One possibility is that scabetic infestation may act as a Koebner stimulus². Inversely, antipsoriatic treatment including the steroid often deteriorates the scabetic lesions.

Second, this situation can lead to the diagnostic problems. In scabies, itching is the most prominent symptom, but it is possible in psoriasis. The scaly lesion of psoriasis often has an appearance similar to the burrow of scabies. Additionally, the scabetic lesion often has the unusual feature by various antipsoriatic therapy. As a result, it takes

more time than we expect to diagnose. It is necessary to consider the possibility of associated dermatoses including scabies, when the severity of psoriasis increases due to an unknown cause or conventional therapy does not work. As to the delayed diagnosis, there is one more area of concern. The Norwegian scabies, which can be very similar to the lesion of psoriasis, tends to occur more frequently and there have been many reports that the diagnosis is delayed^{3,4}.

Third, the appropriate therapy may be difficult to choose in some cases. In our case, the itching sensation improved slightly with antiscabetic treatment, but the severity of psoriasis was unchanged. Systemic treatment was needed, considering the severity of psoriasis. Our patient was unable to take an oral retinoid because she was a young female who had not yet married. And she would not take a phototherapy, as it might aggravate the itching sensation. It is well established in numerous studies that cyclosporine has a potent antipsoriatic effect^{5,6}. Although cyclosporine is an immunosuppressive drug, we judged that a five-day crotamiton therapy was sufficient for the eradication of scabies⁷. In the end, we chose cyclosporine as a systemic treatment for this patient. And it worked; there has been no recurrence of scabies as well as the complete clearance of the psoriatic lesion as ex-

pected. So we think that it is important to select a suitable treatment under a given condition.

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