Read Item - Erosive Pustular Dermatosis

Author: RD Sinclair
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Abstract: Doctors' resource on Erosive Pustular Dermatosis

Key Points

The hallmarks of erosive pustular dermatosis are a boggy mass of pus, with superficial crusting on the scalp of an elderly, partly bald, sun-damaged man or woman that responds to potent topical steroids. It is easily mistaken for an ulcerated skin cancer.

Definition
An inflammatory scarring alopecia confined exclusively to the scalp.

Epidemiology
Erosive pustular dermatosis of the scalp is not as uncommon as was first thought. It occurs in the elderly especially in partly bald, sun-damaged scalps.

Aetiology
The aetiology is unknown. The role of bacterial infection in the aetiology of this condition has been controversial, however it has been shown that the bacteria are a secondary coloniser rather than a primary pathogen.

Pathogenesis
Unknown. The inflammation may be a response to injury to a bald and atrophic scalp.

Clinical features
It is characterised by a large crusted erosion of the scalp. Beneath the crust is a boggy mass containing discreet pustules. The initial lesion can be precipitated by trauma and consists of pustules, erosions and crusts that slowly expand over the scalp and produce a scarring alopecia.

Pathology
Histology from the base of the lesion shows an eroded epidermis, a dense lympho-histiocytic infiltrate in the papillary dermis with scattered plasma cells and foreign body giant cells and replacement of hair follicles by scar tissue.

Investigation
Culture from affected areas often grows Staph. aureus, but other organisms have been also been isolated. A scalp biopsy for routine histology and direct immuno-fluorescence will exclude other causes of scarring alopecia.

Differential Diagnosis
Differential diagnoses include pustular psoriasis, temporal arteritis and cicatricial pemphigoid.

Associated Features
Androgenetic alopecia and solar elastosis are normally seen in the affected areas.

Prognosis
There is no tendency to spontaneous resolution and the condition may have been present many years before the patient presents. Scarring is permanent and the condition tends to relapse on cessation of treatment.

Treatment
Potent topical steroids produce a rapid and dramatic response while antibiotics alone fail to make an impact on the condition. It is prudent to use a combination of potent topical steroids and antibiotics. A remission is ussually induced in about two to three weeks. An astringent such as Burrows solution may be used in the initial stages is there is excessive
weeping.