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Superficial morphea: case report, look-alikes, pathogenesis, and treatment

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Abstract

Superficial morphea, a rare variant of morphea, is characterized by hypopigmented to hyperpigmented skin lesions located predominantly in a symmetric fashion at intertriginous sites. These patches and plaques typically lack the significant induration, contractures, and atrophy seen in other subtypes of morphea. Histologic examination is key for accurate diagnosis considering the number of similar conditions which may clinically mimic superficial morphea. Herein, we present a case of a 25-year-old woman who re-presented for consultation in our clinic after gradual progression of her skin lesions. In addition, we review dermatologic look-alikes, as well as the pathophysiology and treatment options for superficial morphea.

Keywords: superficial morphea, morphea, localized scleroderma, scleroderma

Case Description

A 25-year-old woman previously diagnosed with morphea localized to the left hand was recently referred to the dermatology service owing to progression of her morphea to include the bilateral forearms, flanks, abdomen, chest, axilla, thighs, and posterior knee (Figures 1, 2). Although she initially experienced no change in the sensation of involved skin, she also now noted the development of a feeling of “tightness” in and around some of the affected areas.

The patient had numerous brown, polycyclic patches and plaques located in a symmetric distribution on the forearms crossing the elbow joint, left hand, bilateral inner thighs, bilateral flanks, and central chest (Figures 1, 2). There were several notable plaques on the flanks with an inflamed appearance. The plaques on the bilateral forearms were firmer than those appreciated on the patient’s abdomen and chest.

A punch biopsy of the left upper torso was submitted for pathologic examination and revealed superficial dermal fibrosis with associated patchy inflammation and reactive changes (Figures 3, 4). The histologic features of the deeper levels of the specimen were relatively non-specific. Superficial morphea was diagnosed based on the patient history, clinical examination, and biopsy results.

Initial treatment of the patient’s left hand consisted of topical clobetasol 0.05% and triamcinolone 0.1% cream, which were relatively ineffective. She subsequently underwent a three month trial of narrow-band (nbUVB) without improvement. Topical...
tacrolimus 0.1% ointment was then utilized, yielding mild improvement.

**Case Discussion**

Morphea is a localized form of scleroderma that presents with skin pathology alone - there is an absence of involvement of internal organs, nailfold capillary changes, Raynaud phenomenon, or sclerodactyly, which are typically seen in systemic scleroderma [1]. Morphea manifests clinically with indurated plaques. These lesions typically have a violaceous periphery [6] and occasionally a central white coloration [3]. On histologic examination, classic morphea will manifest with sclerosis and thickening of collagen bundles of predominately the deep reticular dermis but involvement of the upper portions of the reticular dermis as well as the papillary
dermis has also been described [5]. Evidence of linear elastic fibers and loss of CD34-positive dendrocytes is also seen throughout the majority of the dermis with the deeper dermis more heavily involved [6]. Morphea typically has a female predominance with 3:1 female: male ratio with an incidence of approximately 0.4 to 2.7 per 100,000 individuals [1, 3]. There are various subtypes of morphea which include bullous, generalized, guttate, keloidal, linear, plaque, segmental, and the lesser-known superficial form.

Superficial morphea, typically has a clinical presentation consisting of hypopigmented to hyperpigmented patches and plaques that characteristically involve intertriginous sites symmetrically and lack significant induration, contractures, or atrophy [3, 6]. To date there has been no report of any systemic signs and/or symptoms resulting from this morphea sub-type [6]. There has been only one case report of superficial morphea occurring in men [8] with the remaining cases occurring in women [3]. On microscopic examination, skin lesions indicative of superficial morphea will demonstrate sclerosis in, and around the superficial reticular dermis [6]. Other characteristic findings on histology include thickened collagen bundles, decreased fibroblasts and skin appendages, infiltration of lymphocytes in and around vasculature and glands, and reduced or absent staining for CD34 in dermal dendrocytes in the upper portions of the reticular dermis [3, 6]. Parallel elastic fibers seen in the superficial dermis (which may be demonstrated by positive-elastin stains) are distinctive for superficial morphea as these elastic fibers typically organize in a haphazard and disordered fashion throughout the entire dermis [3, 6]. Normal skin structure should be intact in the deeper portions of the reticular dermis and in the hypodermis.

Pathogenesis
The underlying cause of superficial morphea remains unclear. It has been noted that the CD34-positive dendritic cells having potential immunologic properties could play an important role in the pathogenesis of morphea [3, 7]. CD34-positive dendrocytes help regulate collagen synthesis; specifically, with the loss of CD34-positive dendrocytes there is a concordant increase in collagen production [7]. As noted earlier there are decreased numbers of CD34-positive dendrocytes in skin specimens from patients diagnosed with morphea. It has also been reported that an inflammatory response related to microvascular injury contributes to the up-regulation of transforming growth factor beta that subsequently increases collagen production and decreases matrix metalloproteinases resulting in a reduction in collagen destruction [1].

Treatment
Treatments that have been used successfully in classic morphea can be implemented in patients exhibiting the superficial sub-type. These include topical regimens such as potent topical steroids, tacrolimus, imiquimod, and vitamin D analogs. Narrow-band UVB (nbUVB), broad-band UVA (bbUVA), UVA1, and psoralen plus UVA (PUVA) have all been used successfully in the treatment of classic morphea. It should be noted that although UVA1 phototherapy has been shown to be a beneficial treatment, patients require frequent and long exposure times for effectiveness. More importantly, UVA1 is not widely available. Systemic therapies include methotrexate in conjunction with high dose steroids. Mycophenolate mofetil can be added to other systemic therapies for recalcitrant cases [2].
Conclusion

This case serves to raise awareness of superficial morphea, a lesser-known variant of morphea. Appropriate diagnosis requires astute clinical and histopathologic diagnosis. There is currently no uniformly effective and easily accessible treatment available for this frustrating condition.

References