A classic case of erythrodermic psoriasis

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Background
Erythrodermic psoriasis is a rare and potentially life-threatening subtype of psoriasis, occurring in less than 3 percent of patients.[1] It is characterized by erythema involving more than 75 percent of the body surface area and the presence of scaling, exfoliation/desquamation, and/or pustules.[2] Systemic symptoms may include fever, chills, malaise, tachycardia, and arthralgias. The majority of cases are attributed to an exacerbation of pre-existing psoriasis.[2] Important triggers include medications (e.g. treatment with systemic glucocorticoids or abrupt withdrawal of anti-psoriatic medications), infections, alcohol consumption and stress.[2] Increased susceptibility to skin infections is an important complication. Diagnosis is based on patient history, ruling out other causes of erythroderma, and/or skin biopsy.[3] Given the rarity of erythrodermic psoriasis, treatment guidelines are limited. Cyclosporine or infliximab are suggested as first line treatment options given the rapid onset of action, although acitretin and methotrexate can also be used.[4]

Case Presentation
A 67-year-old male presented to the emergency department with a two-month history of a confluent erythematous rash. The rash started on his right leg, and over the course of one week had spread to cover his left leg, torso, back and both arms. It was blanchable, pruritic and had some dry scaling overlying the arms, but was not painful. He otherwise felt well.

The patient had a known history of psoriasis. Prior to the rash eruption, he had a small patch of scaly erythema that was treated with a short course of topical steroids. His case was complicated by a history of a dog bite around the time of the rash eruption, which was treated with a series of antibiotics with no improvement. Dermatology thought that the rash was likely in keeping with erythrodermic psoriasis with a differential including drug eruption and pityriasis rubra pilaris. A skin biopsy was done, which was non-diagnostic but showed no features of pityriasis rubra pilaris or psoriasis. The patient was treated with cyclosporine 100 mg PO BID. At a 1 month follow up, his rash had significantly improved, and he was continued on cyclosporine by dermatology.

Conclusions
This case illustrates the uncommon and severe complication of psoriasis that is characterized by widespread erythema. It is important to consider erythrodermic psoriasis in the differential diagnosis of a patient with an erythrodermic rash, especially if there is a history of psoriasis.

Works Cited
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