

COMMENTARY

Clinical and trichoscopic aspects of scalp psoriasis: commentary to 'Clinical and trichoscopic features in various forms of scalp psoriasis' by F. Bruni et al.

Scalp involvement is very common in psoriasis, being present in up to 80% of patients. The clinical presentation is variable, ranging from minimal scaling to thick plaques covering the whole scalp. Prompt diagnosis and treatment are important, as scalp psoriasis may greatly impact on patients' quality of life (QoL) due to itching, pain, bleeding and feelings of embarrassment due to scales clearly visibly on dark clothing, all causing severe psychological and social impairment, especially in young subjects.^{1,2} The special consideration for scalp psoriasis, that is traditionally considered a difficult-to-treat disease, is also highlighted by the increasing number of studies evaluating the use of biologics and small molecules for its management.³

Although the clinical diagnosis of scalp psoriasis is generally straightforward, it may be sometimes troublesome in case of exclusive scalp localization, minimal lesions and/or atypical presentation, thus requiring a biopsy. In the last years, dermoscopy (also called trichoscopy when used for the evaluation of hair and scalp disorders) considerably enhanced the clinical diagnosis of psoriasis reducing the need for histopathological examination. It shows a typical pattern of homogeneously distributed red dots and whitish scales on a pinkish background. The red dots, that have been also described as red globules, twisted loops or bushy capillaries depending on the magnification used, correlate to the histopathology clue of dilated and tortuous capillaries within elongated dermal papillae that are typical of psoriasis.⁴ The presence of homogeneously distributed red dots represents the most common trichoscopic feature of psoriasis also on the scalp,⁵ generally allowing a fast and easy differential diagnosis with other erythematous disorders, such as seborrheic dermatitis, atopic dermatitis and/or discoid lupus erythematosus, that do not show this vascular pattern.

In this issue of *The Journal*, Bruni *et al.*⁶ report their experience in the evaluation and management of 156 patients affected by scalp psoriasis and propose a clinical classification of the disease into seven patterns, respectively, plaque psoriasis, thin scales, sebopsoriasis, psoriatic cap, pityriasis amiantacea, cicatricial psoriatic alopecia and pustular psoriasis. This attempt of classification based on what observed in clinical practice is

intriguing, especially for its therapeutic implication, as it could help to the development of different approaches based on the different psoriatic patterns, addressing the physician to the most appropriate management. Nevertheless, as overlaps between these forms may be observed, this classification should be validated by an expert consensus or a multicentre study aimed to evaluate the interobserver agreement.

The trichoscopic evaluation also performed in Bruni's study confirms that the characteristic vascular pattern of psoriasis is generally observed also on the scalp and is useful for the differential diagnosis with other disorders. The subtle distinction between 'red loops', 'bushy red loops', 'signet red ring vessels' and 'red dots and globules', differently observed by the authors in the various subtypes, and all expression of the same histopathological basis, is potentially interesting and should be better standardized according to the magnification used, although the application in clinical practice is not easy.

Another important point raised by the authors is the rare, but possible onset of cicatricial alopecia in the course of long-standing, severe, scalp psoriasis, as observed in four patients. Physicians should be aware of this occurrence, as most textbooks still indicate that psoriasis of the scalp is not associated with definitive hair loss.

Finally, the assessment of patients' QoL using the Dermatology Life Quality Index in Bruni's work confirms that the psychological distress related to scalp psoriasis, mainly due to itching and furfureaceous flaking, is high and often irrespective to its clinical severity.

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Conflict of interest

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