



Differential Diagnosis of Chronic Plaque Psoriasis

Disease	Notes
Eczema	Erythematous papules and plaques that lack a silvery scale and may be vesicular and weeping. Chronic old lesions, especially on the hands and feet, may be lichenified and hyperkeratotic (difficult to distinguish from psoriasis). Eczema usually involves the flexures, whereas psoriasis involves the extensor surfaces. Eczema is usually more pruritic than psoriasis. Atopic eczema patients may have a personal or family history of asthma, hay fever, allergies, etc. Discoid eczema does not have silvery scales or tiny bleeding points when scale is removed (Auspitz sign).
Cutaneous T-cell lymphoma (CTCL)	Erythematous patches and plaques with predilection for double-covered areas (breasts, buttocks). Long "prodrome" of unexplained dermatitis usually precedes diagnosis of CTCL
Dermatophyte infection	Solitary or many erythematous lesions with central clearing and peripheral scale. Occasionally, deep inflammatory nodules may be present. KOH prep, fungal culture, and rarely skin biopsy reveal fungal infection. Dermatophytes may involve psoriatic nails with increased frequency.
Superficial squamous cell carcinoma/basal cell carcinoma	Solitary or many patches usually on sun exposed areas that increase in size with time and are refractory to topicals. Skin biopsy confirms the diagnosis. Lesions are usually flat and less erythematous than psoriasis. Classic silvery scale of psoriasis is absent.
Pityriasis rosea	1-2 weeks after a vague "viral" episode, a single "ringworm-like" patch appears on the trunk (herald patch). Smaller lesions with collarettes of scale follow over a few days. The lesions are most commonly on the trunk and follow skin cleavage lines. Epidemics of this viral exanthem (human herpes virus 6) occur in the spring and fall. Usually a self-limiting disease that lasts 8-12 weeks and requires therapy with topical cortisones and antihistamines, or rarely phototherapy only if pruritic. Pityriasis rosea is not usually recurrent.
Subacute cutaneous lupus erythematosus	Predominantly photodistributed psoriasiform lesions. Psoriasis decreases with sun whereas lupus worsens. Biopsy may be helpful along with lab tests (anti-ssA [anti-Ro] and anti-ssB [anti-La]). When anti-ssA is done using ELISA, it is always positive in subacute cutaneous lupus.
Secondary syphilis	Erythematous psoriasiform papules with a collarette of scale scattered on the body, including hands and feet. Associated skin findings include nonscarring alopecia, mucous patches in the mouth, and lymphadenopathy. Systemic symptoms, such as malaise, fever, headache, and myalgias, are usually present. Primary lesion (chancre) may still be evident in early stages of secondary syphilis. Confirm suspected diagnosis with syphilis serology.

ELISA = enzyme-linked immunosorbent assay.

Table from *Physicians Information and Education Resource (PIER)*, Psoriasis module.