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A Case Report of a Morphea in a 19 Years Old Female

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Abstract:- The objective to describe a rare case of morphea disease, it is an autoimmune disease in which an elevated in collagen production and a decrease in collagen destruction.. Morphea has various clinical features, its usually present in patches and bands with dense skin, hands & legs, head, and torso regions.A 19-year-old female patient was admitted to the female derma ward with the chief complaint of a blackish raised lesion over the right side of the shoulder, right lower waist, right side upper thigh, and raised lesion over the left side back of the neck for 3.5 years. Medications were prescribed to patient. Morphea's yearly event rate is about 0.4 – 2.7 cases per one lakh. Early diagnosis and treatment is preffered, if cannot be treated patient condition get worsen over time.

Keywords:- *Morphea , Corticosteroids Therapy , Collagen.*

I. INTRODUCTION

Morphea is an uncommon autoimmune disease and it is also called localized scleroderma. It commonly occurs in children age group between 2 to 14 years and effectively shows in women. Morpheahas various clinical features, its usually present in patches and bands with denseskin,hands& legs, head,and torso regions. Morphea can cause skin atrophy and darkened patches or spots on the skin, impairing thepatient's quality of life and physical impairment. During the morphea disease condition in patients, there are periods of swelling with new development and enlargement fester, leading to sclerosis. [1,2]. Morphea occurs in two stages first is an active or inflammatory stage and the second is stage is burnt stage. Therapy is given duringthe active phase to prevent new lesions' development. Morphea can be classified into Circu1mscribed Morphea ,Linear Morphea ,Generalized 4, Pansclerotic Morphea ,Mixed Morphea. [3] .There is no cure for morphea. There are currently no licenced therapies for the treatment of morphea, and clinical management of the disease is largely empirical . [4] Many treatments have been proposed. If sclerosis and atrophy have already been established, the results vary in the acute inflammatory phase and are scarce. [5]. The most generally specified remedy was topical corticosteroids (63%). Dermatologists generally specified topical treatments or phototherapy independently, indeed to cases with direct and generalized morphea. In discrepancy, rheumatologists generally specified systemic immunosuppressives and physical remedy. [6] The diagnosis of morphea is substantially clinical, through history and careful physical examination of the skin. The interogation of the case about elaboration of the lesions or comparison with former photos is relatively helpful, as well as relating the different morphology patterns shrine or circumscribed, direct, generalized, superficial or deep.[7]

II. CASE REPORT

A 19-year-old female patient was admitted to the female derma ward with the chief complaint of a blackish raised lesion over the right side of the shoulder, right lower waist, right side upper thigh, and raised lesion over the left side back of the neck for 3.5 years. History of present illness was she noticed blackish raised lesions present over the right side of her shoulder, right lower waist & right side upper thigh which was hard in nature, and a whitish raised lesion present over the left side back of her neck, which was hard in nature, not associated with itching burning sensation. Laboratory investigation of the hematology report shows TRBC (4.40 million/comm), MCV (80 FL), MCHC (35.8 g/dl), and PCV (34.4 %). In biochemistry investigation triglycerides (204 mg/dl) and VLDL (40.80 mg/dl). Skin punch biopsy from right flank favors Morphea. Based on history examination and investigation diagnosis of Morphea was made. The patient was treated under the expert guidance of a dermatologist.

III. DISCUSSION

Morphea's yearly event rate is about 0.4 – 2.7 cases per one lakh. The pathogenesis of morphea is unknown but it is found that in morphea conditions an elevated in collagen production and a decrease in collagen destruction.

[3] Some of the hallmarks of morphea are (A) Vascular dysfunction – It shows the presence of Raynaud's phenomenon and visible nail fold. (B) Immune dysregulation – In recent studies, class I allele HLA and class II allele DRBI are involved in morphea.(C) Cytokines and chemokines - Increased in serum level of adhesion molecule vascular cell adhesion molecule I (VCAM- I) and intracellular cell adhesion molecule I and E- selectin are increased in morphea. IL-4, IL-6, IL-8, and IL-13 are also increased in morphea.(D) Excessive extracellular matrix formation- a key feature of morphea is the development of cutaneous and subcutaneous fibrosis, it is due to an increase in collagen production or a decrease in collagen destruction. [4].A 19-year-old female patient was admitted to the female derma ward with the chief complaint of a blackish raised lesion over the right side of the shoulder, right lower waist, right side upper thigh, and raised lesion over the left side back of the neck for 3.5 years. The patients received Care from a team of health professionals in the dermal department, clinical pharmacist and nursing staff. After getting proper care from the health care professional her symptoms got relieved and she has to take medicines as prescribed. Her parents were counseled properly to take care of his child and do suggested medication properly for more improvement.

IV. CONCLUSION

In this report, we discuss an uncommon case of morphea disease. Our study reports that her symptoms got relieved after taking proper medication and proper counseling done by dermatologist. This case highlights the importance of corticosteroids and early diagnosis. Early examination can prevents future complications.

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REFRENCES

[1].Wenzel, D., Haddadi, N., Afshari, K., Richmond, J. M., &Rashighi, M. (2021). Upcoming treatments for morphea. Immunity, Inflammation, and Disease. doi:10.1002/iid3.475.

[2].O'Brien, J. C., Nymeyer, H., Green, A., &Jacobe, H. T. (2020). Changes in Disease Activity and Damage Over Time in Patients With Morphea. JAMA Dermatology. doi:10.1001/jamadermatol.2020.00.

[3].Fett, N. (2012). Morphea: Evidence-based recommendations for treatment. Indian Journal of Dermatology, Venereology, and Leprology, 78(2), 135. doi:10.4103/0378-6323.93628.

[4].Fett, N. (2012). Morphea: Evidence-based recommendations for treatment. Indian Journal of Dermatology, Venereology, and Leprology, 78(2), 135. doi:10.4103/0378-6323.93628.

[5].Zanelato TP, Marquesini G, Colpas PT, Magalhães RF, Moraes AM. Implantation of autologous fat globules in localized scleroderma and idiopathic lipoatrophy--report of five patients. An Bras Dermatol. 2013 Nov-Dec;88(6 Suppl 1):120-3. doi: 10.1590/abd1806-4841.20132115. PMID: 24346897; PMCID: PMC3875985.

[6].Johnson, W., &Jacobe, H. (2012). *Morphea in adults and children cohort II: Patients with morphea experience delay in diagnosis and large variation in treatment. Journal of the American Academy of Dermatology, 67(5), 881–889.* doi:10.1016/j.jaad.2012.01.011

[7].Rodríguez-Salgado, Pamela, and María Teresa García-Romero. "Morphea: a practical review of its diagnosis, classification and treatment." *Gacetamédica de México* 155.5 (2019): 483-491.