

## Atypical porphyria cutanea tarda mimicking morphea

### *Porfíria cutânea tarda atípica mimetizando morfeia*

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A 65-year-old man with a history of alcohol abuse presented with cicatricial alopecia and whitish sclerotic plaques in the upper chest, distributed mainly on the V area of the lower neck and lower sternum (Fig. 1). In addition, physical examination revealed a hyperpigmented area of hypertrichosis on the interparietal and left parietal region (Fig. 2).

Laboratory evaluation showed iron overload and elevated transaminases. Antinuclear antibodies and infectious serologies, including borrelia, were negative. A cutaneous biopsy of the scalp and neck was compatible with morphea, and thus, narrow band ultraviolet B phototherapy was initiated.

One month later, the patient reported blistering and crusting of the forearms. Urine analysis revealed increased uroporphyrins establishing the diagnosis of porphyria cutanea tarda (PCT). The patient was started on bimonthly phlebotomies, and photoprotection and alcohol withdrawal were recommended.

Sclerodermiform changes have been reported in 2% of PCT patients<sup>1,2</sup>. Clinically, lesions may resemble morphea, presenting with hyperpigmentation rather than a



**Figure 1.** White-yellow atrophic plaques in the “V” area of the upper chest with a hyperpigmented border.

peripheral lilac ring<sup>3,4</sup>. Scalp lesions may present as scarring alopecia, also called alopecia porphyrinica<sup>3</sup>. Isolated sclerodermiform changes, without the typical clinical picture of PCT, pose a diagnostic challenge. Histopathology

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Received: 20-04-2023

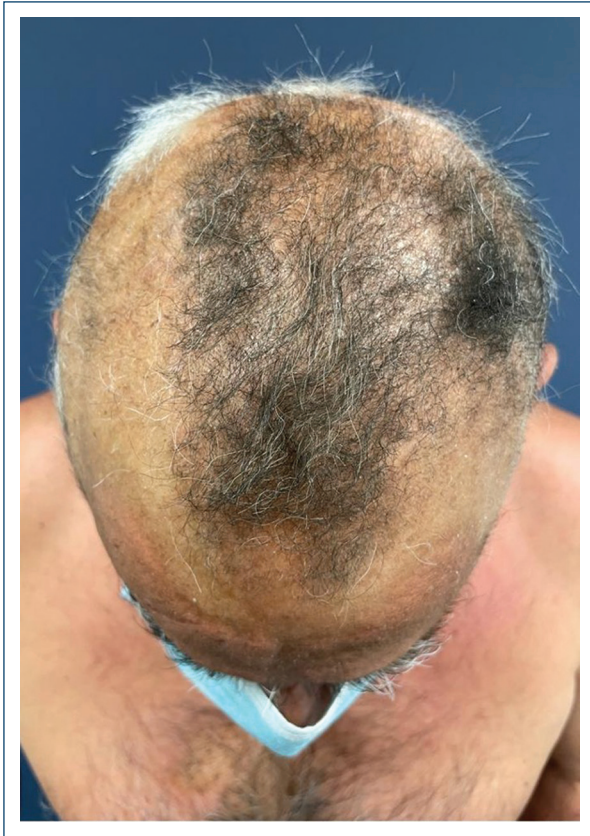
Accepted: 26-07-2023

DOI: 10.24875/PJDV.23000030

Available online: 20-12-2023

Port J Dermatol and Venereol. 2023;81(4):293-294

[www.portuguesejournalofdermatology.com](http://www.portuguesejournalofdermatology.com)



**Figure 2.** Alopecic patches on the scalp and hyperpigmented area of hypertrichosis on the interparietal and left parietal region.

cannot reliably distinguish morphea from sclerodermiform PCT<sup>4</sup>. Given the clinical and pathological resemblance, one must consider this alternative diagnosis, especially when facing therapy failure.

## Funding

None.

## Conflicts of interest

None.

## Ethical disclosures

**Protection of human and animal subjects.** The authors declare that no experiments were performed on humans or animals for this study.

**Confidentiality of data.** The authors declare that they have followed the protocols of their work center on the publication of patient data.

**Right to privacy and informed consent.** The authors have obtained the written informed consent of the patients or subjects mentioned in the article. The corresponding author is in possession of this document.

**Use of artificial intelligence for generating text.** The authors declare that they have not used any type of generative artificial intelligence for the writing of this manuscript, nor for the creation of images, graphics, tables, or their corresponding captions.

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