

Seborrhoeic pattern of parthenium dermatitis

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We report two patients with parthenium dermatitis who presented with involvement of seborrhoeic areas mimicking seborrhoeic dermatitis. Both of them had contact allergy to *Parthenium hysterophorus*.

Patient 1

For 10 years, a 50-year-old non-atopic housewife had recurrent episodes of pruritic, non-exudative, erythematous papules, which first appeared on the face and later gradually spread to involve the neck. She gave a history of involvement of the antecubital and popliteal fossae, upper eyelids, retroauricular areas, and abdomen. Her condition was worse in the summer months. She did not recognize parthenium and was unaware of the plant in her environment. Examination showed involvement of her face, primarily the nasolabial folds and forehead but also the eyebrows, chin, earlobes, retroauricular areas, and neck in the form of erythematous and lichenified papules without scaling (Fig. 1). The eyelids and the scalp were not involved. Patch testing with the Indian standard series and an

acetone extract of parthenium (in dilutions of 1:100 and 1:200) was performed (1, 2); she was found to have contact allergy to parthenium (Fig. 2). She was treated with topical steroids, azathioprine, and photoprotection.

Patient 2

A 40-year-old non-atopic housewife had a 2-year history of erythematous, exudative papules, which started around the perioral area and cheeks and subsequently involved the antecubital and popliteal fossae. Gradually, the lesions spread to involve the neck and feet. She also had a past history of eyelid dermatitis. There was near complete remission in winter. Her dermatitis developed after moving from the city to the suburbs. She recognized parthenium and acknowledged its presence in her environment. Examination showed erythematous, lichenified papules and plaques on her nasolabial folds, upper and lower lips, chin, forehead, neck, and 'V' of the chest (Fig. 3). Discrete, hyperpigmented lichenified papules were also present on the forearms and feet. The eyelids and the scalp were not involved. Patch testing with the Indian standard series and an acetone extract of parthenium (in dilutions of 1:100 and 1:200) was performed (1, 2); she showed contact allergy to parthenium. She was treated with topical and systemic steroids, azathioprine, and photoprotection.

Discussion

Allergic contact dermatitis to *P. hysterophorus* presents with a spectrum of clinical patterns (2, 3). The classical pattern is of a distribution, which primarily affects the exposed parts of the face, the eyelids, neck, 'V' of the chest, and the antecubital and popliteal fossae (3). Other patterns include chronic actinic dermatitis-like pattern (3), mixed pattern dermatitis (3), prurigo nodularis (4), photosensitive lichenoid eruptions (5), hand and feet dermatitis (3), and extensive dermatitis (3). Both of our patients had a seborrhoeic dermatitis-like pattern that is not well documented and was not seen in our recent series of 74 patients with parthenium dermatitis (3).



Fig. 1. Eczematous lesions on the face: mainly nasolabial fold, chin, and forehead, including the eyebrows (patient 1).

Tiwari et al. (6) in 1979 described a seborrhoeic pattern in 5 of their 50 patients with parthenium dermatitis. They had itchy, dry, pigmented lesions involving the nasolabial folds, upper lip, chin, cheeks, eyebrows, retroauricular folds, chest, and upper back. They also had variable amount of dandruff, and the authors thought that these patients

had contact dermatitis superimposed on seborrhoeic dermatitis. But in our cases, the previous history of eyelid and flexural involvement, presence of lichenified papules, and positive patch tests to parthenium extracts, in the absence of other evidence of seborrhoeic dermatitis, suggests parthenium dermatitis. It is probable that the airborne allergens of parthenium can



Fig. 2. Patch test contact sensitivity to the acetone extract of parthenium in 1:100 (marked as number 2) and 1:200 dilutions (marked as number 3) (patient 1).



Fig. 3. The severe involvement of the seborrheic areas (patient 2).

accumulate in the nasolabial folds (in addition to the eyelids) in persons having deep and prominent folds.

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