

Rough Pigmented Skin Around the upper Gluteal Cleft —the Condition Called Senile Gluteal Dermatitis, Hyperkeratotic Lichenified Skin Lesion of Gluteal Region, Ano-sacral Cutaneous Amyloidosis and Gluteal Skin Roughness—

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ABSTRACT

Rough pigmented skin is often seen around the upper gluteal cleft in the elderly. It is considered to be induced by friction, pressure and long hours sitting. Some cases revealing amyloid deposits may be accompanied by other cutaneous amyloidosis. Bedsores and fungal infection can occur as complications. This condition should be known widely among people taking care of the elderly.

Key words: Senile gluteal dermatitis; Hyperkeratotic lichenified skin lesion of gluteal region; Ano-sacral cutaneous amyloidosis; Gluteal skin roughness; Friction

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EDITORIAL

Elderly persons often get rough pigmented skin around the upper gluteal cleft. Hyperkeratotic parallel ridges and scale are seen in most lesions. Hypertrophy, papules, erythema and ulcers are done in some (Figure 1). Histology mostly reveals hyperkeratosis, acanthosis and follicular plugging (Figure 2). Friction, pressure and long hours sitting are considered to be triggers^[1]. The general term for this condition seem to be unified to “senile gluteal dermatitis”, which was proposed by Boss & Koning in 1992^[2]. Recently Liu *et al.*^[1,3] and Moon *et al.*^[4] examined the large number of cases and reported them using this term. They described that this condition was first reported in Japan as “hyperkeratotic lichenified skin lesions of gluteal region”^[5]. The author here summarizes the discussions about it in Japan.

There was the first debate in a Japanese dermatological meeting in 1978. Yamamoto & Mukai presented this condition as the result of mechanical stimulation in the elderly, and discussed with Mori who insisted that some cases belonged to a special type of cutaneous amyloidosis^[5]. In 1979 Yanagihara & Mori *et al* proposed the term “ano-sacral cutaneous amyloidosis” in another meeting, and discussed with Yamamoto again^[6]. After those the debates continued on journals. In 1981 Yanagihara published a paper “ano-sacral cutaneous amyloidosis”^[7]. He reported nine cases revealing amyloid deposits characteristically around follicles, and insisted it as a new type of cutaneous amyloidosis. The cases presented by Yamamoto & Mukai were considered to be the same as ano-sacral cutaneous amyloidosis in his paper. In 1985 Yamamoto & Mukai examined 14 cases by Dylon and Thyoflavin T stains, which react to amyloid^[8]. Two cases showed no amyloid deposits, 10 did slightly, and two did abundant amyloid masses. Normal gluteal skins of three elder persons were also stained. Two of them revealed a small amount of amyloid. They concluded that amyloid did not mainly cause this condition and

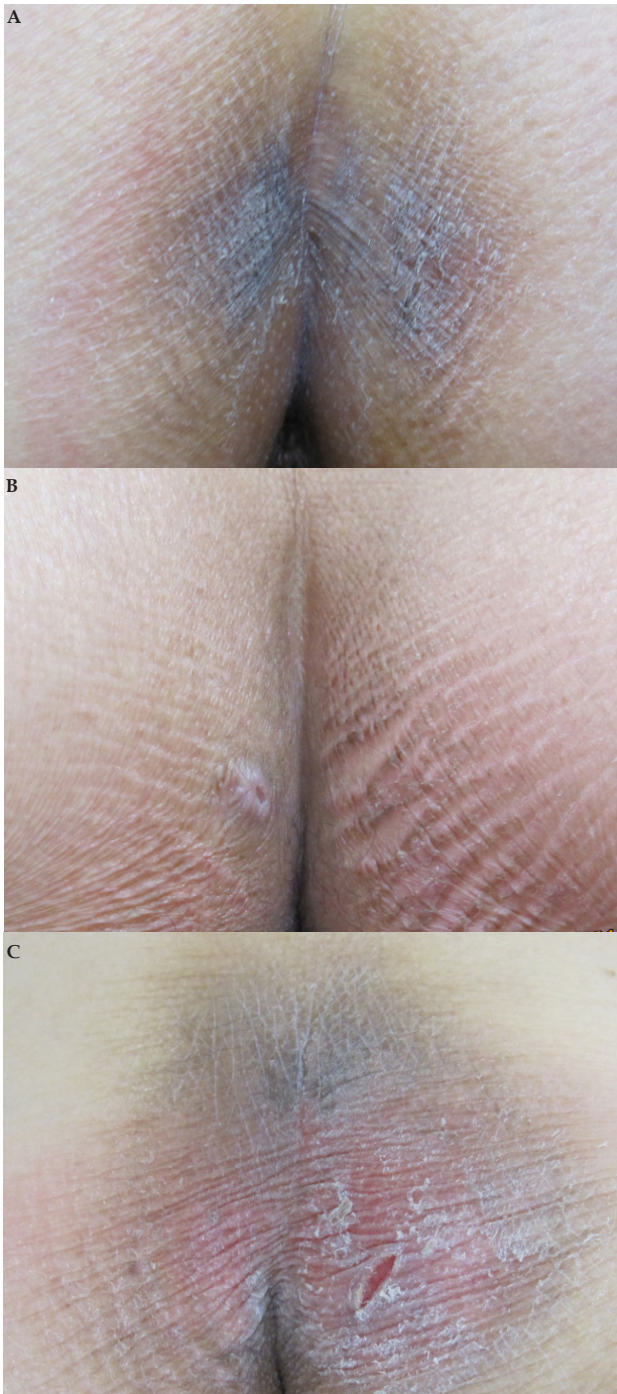


Figure 1 (A) A typical lesion revealing roughness and pigmentation. (B) A lesion with a papule. (C) A lesion with erythema and a small ulcer.

proposed the term “hyperkeratotic lichenified skin lesion of gluteal region”. In 1986 Mukai & Yamamoto *et al* wrote another paper to accept ano-sacral cutaneous amyloidosis as an entity different from hyperkeratotic lichenified skin lesion of gluteal region^[9]. They reported five cases which revealed amyloidosis not only in gluteal regions but also in other cutaneous parts. Wakashin detected amyloid deposits in three cases out of eight in 1998^[10]. Only a case showed them around the follicles. His autopsy experiences concluded that amyloid fibers were often seen in many organs of elderly persons as a kind of aging phenomenon. In 2000 Kojima proposed the third term “gluteal skin roughness”^[11]. He described that this condition might arise in the aged carrier of hyperkeratotic diseases such as

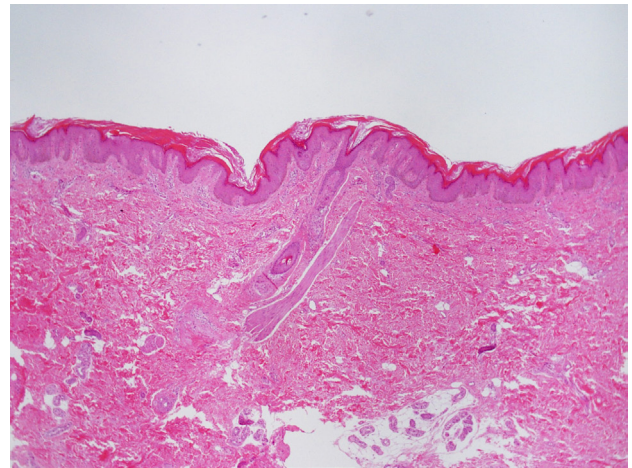


Figure 2 Histology shows hyperkeratosis, epidermal hyperplasia and follicular plugs (×40).

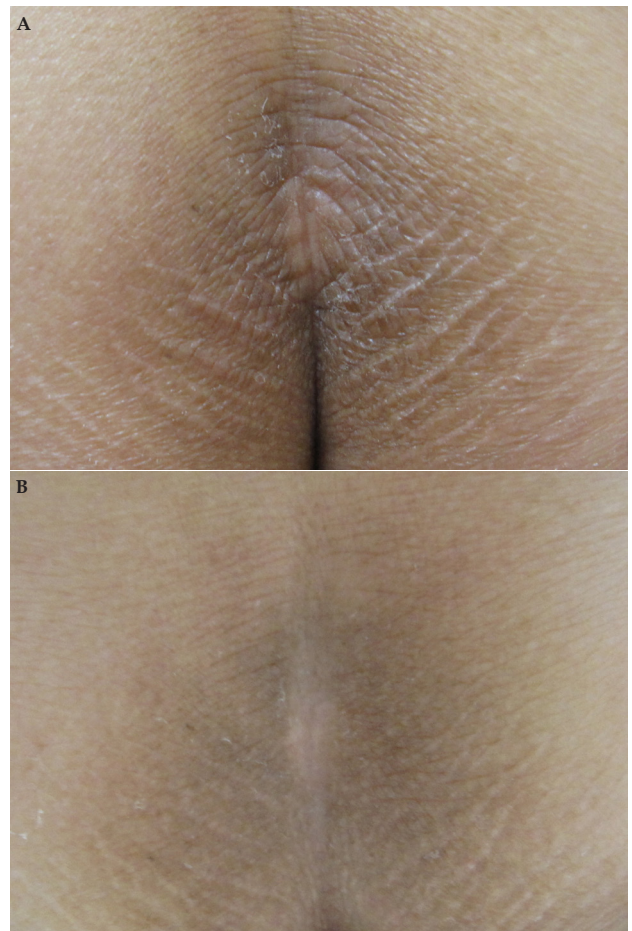


Figure 3 (A) A lesion before the treatment of activated vitamin D3 ointment. (B) An improved lesion after the treatment for four weeks.

lichen pilaris. Recently Ishizaki *et al* have recommended the third term because it is easy to understand^[12]. These above papers were published in Japanese language.

There are some reports from Taiwan and Korea after 2000. Wang *et al* reported 10 cases of ano-sacral cutaneous amyloidosis proved by histological examinations including crystal violet, Congo red and Dylon stains^[13]. Half of their cases developed the disease before the age of 60 years. In their cases amyloid deposits were not present around the hair follicles unlike Yangihara’s observation. Eight cases

of them involved other cutaneous amyloidosis. Liu *et al* described clinicopathologically 12 cases of senile gluteal dermatosis and 11 of ano-sacral cutaneous amyloidosis, and insisted on distinguishing them^[3]. Liu *et al*^[1] reported 137 cases of senile gluteal dermatosis and Moon *et al*^[4] did 37 cases. Skin biopsies were performed in only 14 and eight cases respectively. They could not exclude cases of ano-sacral cutaneous amyloidosis.

It is impossible to distinguish these two diseases clinically. Most

physicians will probably make diagnoses of senile gluteal dermatosis without histological examinations. The existence of amyloid deposits may not be important, however, it must be doubted. Some cases are accompanied by other cutaneous amyloidosis^[9,13]. Topical steroids are thought to be not effective for senile gluteal dermatosis. Some lesions react to activated vitamin D3 ointment^[14] (Figure 3). Wound covering materials are effective for hypertrophic lesions, but are improper for long-term use (Figure 4). It is the most important not to sit on hard furniture or mats for long hours. Some cases are complicated with bedsores and fungal infection. This condition should be known widely among people taking care of the elderly. A simple term is preferable.

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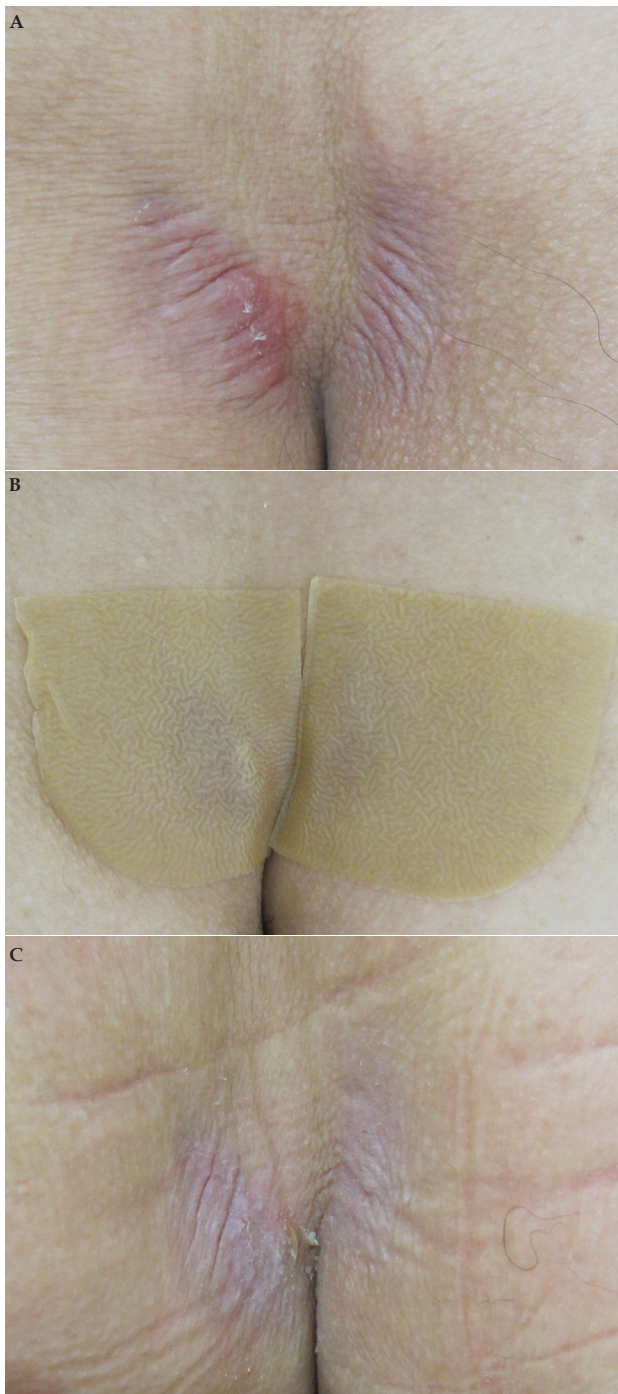


Figure 4 (A) A hypertrophic lesion before the treatment. (B) Applying wound covering materials. (C) An improved lesion after the treatment for a week.