MORPHOEA (LOCALISED SCLERODERMA)

What are the aims of this leaflet?

This leaflet has been written to help you understand more about morphoea (localised scleroderma). It tells you what it is, what causes it, what can be done about it, and where you can find out more about it.

What is morphoea?

Morphoea, also known as localised scleroderma, is uncommon (fewer than 3 per 100,000 people). The word ‘scleroderma’ originates from two words, ‘sclero’ meaning ‘hard’ and ‘derma’ meaning ‘skin’. These are the main feature of morphoea, with areas of morphoea being thicker and firmer than the rest of the skin.

Morphoea should not be confused with systemic sclerosis, in that the damage in morphoea occurs only in the skin, and does not affect internal organs as happens in systemic sclerosis. However, morphoea itself is not one disease with one prognosis. Types of morphoea include: plaque, linear (with a special linear type on scalp called ‘en coup de sabre’), and the generalised type. These types will be discussed later on.

What causes morphoea?

The exact cause of morphoea is not known but it is not contagious or hereditary. The hardness of skin is due to excessive production of collagen, a protein in skin that gives normal skin its strength. Morphoea usually appears for no apparent reason although sometimes it may be triggered by an event such as a minor injury, insect bite, or a viral infection such as chickenpox. It can affect anyone, but is most common in children (two thirds are under 18 years only), about 80 % are whites and nearly three quarters are females.
What does morphea look like?

Areas of reddish thickened skin (which can sometimes be slightly raised and called ‘plques’) expand in area size. The areas become yellowish white and smooth often with a violet or lilac colour border. Older areas tend to become brown and last for months. Other types of morphea beside the plaque type include linear and generalised.

The affected areas typically range from 2 to 15 cm (1 to 6 inches) in diameter. They may be single, but usually there are several of them. In 10% of cases there may be widespread thickening of the skin (termed ‘generalised morphea’). Hair and sweat glands may be lost over the affected areas and the skin may feel dry. The shape is typically round or oval but may be distributed in a line (termed ‘linear morphea’). Rarely in linear morphea involvement of tissue below the skin surface (e.g. fat, muscle and bone) may be affected. In one variety of linear morphea, a narrow groove runs up over the forehead into the scalp (termed ‘en coup de sabre’), where it shows up as a line of hair loss.

How can morphea be diagnosed?

Clinical recognition of the condition is essential for an early diagnosis and treatment. The well trained dermatologist will recognise morphea by its appearance, but a skin biopsy (a small piece of the skin, removed under a local anaesthetic) may be taken and looked at under the microscope in the laboratory to confirm the diagnosis. Blood tests may be helpful to exclude other conditions.

Can morphea be cured?

Overall, the plaque type of morphea can be expected to improve on its own over 3-5 years but it might take longer for the linear, deep and generalised subtypes.

How can morphea be treated?

The treatment for morphea depends on the type identified by your doctor. The earlier the treatment, the better the outcome especially in the linear, deep and generalised forms.

Plaque morphea, the commonest form, does not always need treatment, as it will usually improve by itself. However, potent steroid creams or ointments
or a non steroid cream such as tacrolimus are sometimes used as they may help to reduce inflammation and prevent progression.

In rare severe cases, oral or intravenous steroids may be given as well as other therapies such as methotrexate (covered in other leaflets in this series). Ultraviolet light therapy may also be used to treat extensive morphoea.

If the affected skin of a limb causes its movement to be affected, involvement of rheumatologists and orthopaedic surgeons and physiotherapists may be considered. If morphoea affects the skin of the face, plastic surgeons and maxillofacial surgeons may be considered.

**Self care (What can I do?)**

General skin care, with regular use of moisturisers and the use of creams or lotions as a soap substitute, may help. It may be of benefit to discuss your concerns and condition with others who have morphoea (see below).

**Where can I find out more about morphoea?**

**Web links to other internet sites:**

www.dermnetnz.org/immune/morphoea.html

**Links to patient support groups:**

*Raynaud’s & Scleroderma Association*
112 Crewe Road
Alsager
Cheshire, ST7 2JA
Tel: 0800 9172494 or 01270 872776
Email: info@raynauds.org.uk
Web: www.raynauds.org.uk

*Scleroderma Society*
Bride House
18-20 Bride Street
London, EC4Y 8EE
Helpline: 0800 311 2756
Email: info@sclerodermasociety.co.uk
Web: www.sclerodermasociety.co.uk
For details of source materials used please contact the Clinical Standards Unit (clinicalstandards@bad.org.uk).

This leaflet aims to provide accurate information about the subject and is a consensus of the views held by representatives of the British Association of Dermatologists: its contents, however, may occasionally differ from the advice given to you by your doctor.

This leaflet has been assessed for readability by the British Association of Dermatologists’ Patient Information Lay Review Panel

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