INTRODUCTION
Pityriasis alba is a self limiting dermatosis. It is regarded as a manifestation of atopic dermatitis. However, non-atopic individuals are also known to have this disease.\(^1\) It can occur in any race but more problematic in dark skinned individuals. In an audit at Hamdard University Hospital, Karachi, the frequency of this disorder was found to be very low as compared to the other dermatological diseases.\(^2\) About 4.9% patients had pityriasis alba in an epidemiological study presented by Sharma in Indian Punjab.\(^3\)

Lesions of pityriasis alba are characterized by rounded, oval or irregular plaque with indistinct margins. The cause of this disease is still unknown. However, many contributory factors are mentioned in the literature including, temperature, humidity, hygiene and altitude. No treatment is usually required and the disease is self resolved within months or a year. This case report presents the ocular features which were found in association with pityriasis alba.

CASE REPORT
A 10 years old Pakistani child came to the out-patient department with history of decreased vision in both eyes for 2 years. He had been prescribed glasses but the compliance was poor. There was no irritation and redness in both eyes. Systemic history revealed whitish patches on the skin, especially around the mouth, chin and on the cheeks. They were round or oval and margins were not well defined. The lesions showed no signs of inflammation but there was history of mild erythema prior to the appearance of these white patches. There was no history of eczema and asthma. There were no signs of thyroid disease, lymphoma and pernicious anaemia. Chest X-ray, CBC and liver function tests were normal. The patient was referred to dermatology department for management. Biopsy was not required for diagnosis and not done in this patient. Clinical features helped in making the diagnosis.

DISCUSSION
Pityriasis is derived from a Greek word which means scaling and flaking. Alba means white in Latin. The patches are not entirely depigmented in this condition.\(^4\) On examination, he was an average built young boy who was well oriented in time and space. He was orthophoric and had hypermetropia. There was recent onset poliosis (Figure 1). Otherwise the eyelids were normal with no signs of blepharitis. Autorefraction showed -12.75 DS with -1.75 DC at 12° in right eye and -11.5 DS with -2.00 DC at 180° in his left eye. His best corrected visual acuity was 6/36 with -5.00 DS in each eye. Anterior segment showed no abnormality. On dilated fundus examination, there were tilted discs in both eyes. Large choroidal vessels were visible due to myopic chorioretinal degeneration which was also involving the macular region.

General physical examination showed normal vital signs. Skin showed hypopigmented lesions on the face especially around the mouth, chin and on the cheeks. They were round or oval and margins were not well defined. The lesions showed no signs of inflammation but there was history of mild erythema prior to the appearance of these white patches. There was no history of eczema and asthma. There were no signs of thyroid disease, lymphoma and pernicious anaemia. Chest X-ray, CBC and liver function tests were normal. The patient was referred to dermatology department for management. Biopsy was not required for diagnosis and not done in this patient. Clinical features helped in making the diagnosis.


dt\(\text{ABSTRACT}\)
Pityriasis alba is a skin disease, commonly seen in children and young adults. This case presents the ocular association of this disease in a 10 years old Pakistani male. Ocular features in this case were poliosis, tilted disc, high myopia and chorioretinal degeneration. Tilted discs and high myopia can be coincidental but poliosis and decreased pigment in retinal pigment epithelium are closely related with the hypopigmentation seen in this disease.

**Key Words:** Pityriasis alba. Poliosis. Vitiligo. Retina.
case and also not in close family members except a history of asthma in one of his paternal uncles.

There are certain possible risk factors. More common are xerosis and mineral deficiency. Sun exposure makes these lesions more prominent. Some studies have shown that it is associated with copper deficiency. In this patient, no history or clinical evidence of xerosis was found. Serum mineral analysis could not be performed.

Three stages of this disease are identified: erythema, scaling and hypopigmentation. Mild scaling and hypopigmentation are the clinical features which are more commonly seen when the patients seek medical advice. Lesions are more prominent around the mouth, cheeks and chin. This patient had hypopigmented lesions on the face especially around the mouth, cheeks and chin as shown in Figure 2. Scaling of the lesions could not be made out. It might be because of the reason that scaling is more common in dry winter while hypopigmentation becomes more prominent in summer. Usually no treatment is required for hypopigmentation and patches heal with time.

There is a large list of hypopigmented lesions of the skin but few are associated with the ocular manifestations. Skin depigmentation is seen in Naevus depigmentosus, cutaneous T-cell lymphoma, vitiligo and pityriasis rosea. Naevus depigmentosus is present at birth or before 3 years. It is a single well demarcated lesion on the trunk with no ocular findings. There are reports indicating ocular involvement in cutaneous T-cell lymphoma but this disease is associated with indolent inflammatory response which was absent in our patient. In pityriasis rosea pink, salmon pink or brown coloured patches are found on the extremities. The extremities were normal in this particular patient and the depigmentation was not pink or brown.

Ocular features in this case were poliosis, tilted disc, high myopia and chorioretinal degeneration. We could not find any of these in any case of pityriasis alba reported so far in the literature.

It was tried to rule out the other causes of poliosis. Common ocular causes of poliosis are chronic blepharitis, sympathetic ophthalmia and uveitis. All of these conditions were absent in this patient. Systemic associations of poliosis include Vogt Koyanagi Harada syndrome, Wardenburg syndrome, vitiligo, Marfan syndrome and Tuberculous sclerosis. Typical skeletal and soft tissue abnormalities associated with Marfan's syndrome were absent in this patient. Absence of adenoma sebaceum, cafe au lait spots, ash leaf spots, shagreen patches and other visceral and neurological signs of tuberous sclerosis ruled out this condition. There were no clinical features suggestive of Wardenburg syndrome and VKH syndrome. In vitiligo, hypopigmentation is well demarcated while the margins of hypopigmentation in that patient were blurred. We searched the literature but did not find any case showing association of poliosis with pityriasis alba.

Tilted disc and high myopia could be chance associations. Pigment deficiency in the retinal pigment epithelium can be either due to myopic degeneration or because of the fact that number of melanosomes are deficient in the lesions of skin of pityriasis alba. Literature reveals that histologically there is no significant difference in the number of melanocytes between the lesional and the normal skin. However, the number and size of melanosomes are reduced in these lesions.

To the authors' knowledge, this is the first report of pityriasis alba with poliosis. Poliosis can be caused by damage to the melanosomes which is histologically evident in the literature. This decrease in the number of melanosomes might be induced by erythema which was seen in the first stage of pityriasis alba. Further research on the ocular associations of this disease is required.

REFERENCES