Sitter's Sign
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Mark V. Dahl, MD reviewing Liu H-N et al. Int J Dermatol 2014 Jan.

Hyperkeratotic lichenified skin lesion of the gluteal region is a cumbersome name that describes the condition very well.

Elderly men often develop rough skin near the gluteal fold associated with immobility. This disorder is called senile gluteal dermatosis (SGD) or hyperkeratotic lichenified skin lesion of the gluteal region. (The latter name, although more cumbersome, describes the disorder well.) Poorly defined brown to grey plaques develop slowly on the gluteal cleft and, often, also on the adjacent buttocks. These may be asymptomatic or tender when sitting, but sometimes they itch instead. Researchers in Taiwan set out to study the incidence and predisposing and provoking factors of this disorder.

They examined 162 consecutive outpatients with skin lesions of the buttocks. SGC patients had brownish scaly plaques on the gluteal cleft and each side of the buttocks, roughly in the shape of triangles. Patients with tinea, candidiasis, or cutaneous amyloidosis (macular amyloidosis) were excluded. The authors identified SGD in 137 (85%) of the patients (130 men). Mean body-mass index was 21.7 +/- 10. Plaques were most common over the ischial tuberosities but not necessarily over the coccygeal apex. In about 15% of patients, skin lesions occurred on the buttocks but not on the gluteal fold, and on only one buttock in some. Hyperkeratotic ridges were noted in 53%, and 4 patients had ulcers of various depths. Inflammation with features of psoriasis was noted in 10 patients.

Most patients also had systemic diseases such as hypertension, diabetes, neurologic disorders, spine or knee problems, or congestive heart failure. The root causes seemed to be prolonged sitting, pressure, friction, and, on average, a low mean body mass. Biopsy specimens showed psoriasiform epidermal hyperplasia with elongation of the rete ridges. Most specimens showed scant inflammation. Most patients were dissatisfied with prescribed topical treatments (corticosteroids, urea, or salicylic acid). Pressure-relieving devices, such as donut cushions or air or water-filled cushions, worked better.
Comment: In my experience, this is indeed a common problem in elderly, thin, frail, relatively immobile men of Asian descent. Most patients correctly attribute the problem to prolonged stints of sitting and complain for the most

part only when plaques are sore. The disorder needs a better name. I prefer “sitter's sign” because it suggests immobility.