DISSEMINATED SUPERFICIAL ACTINIC POROKERATOSIS

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Disseminated superficial actinic porokeratosis in a 40-year-old man is described. The diagnosis was confirmed by histopathology in which the classical cornoid lamella was seen.

Key Words: Porokeratosis, Disseminated superficial actinic porokeratosis, Cornoid lamella

Introduction

Porokeratosis is a chronic, progressive hereditary disease. Five different types of porokeratosis have been mentioned. They are plaque type described by Mibelli, disseminated superficial actinic porokeratosis (DSAP), linear porokeratosis, porokeratosis plantaris palmaris et disseminata and punctate porokeratosis. The skin lesions of disseminated superficial actinic porokeratosis are most pronounced on sun exposed areas and may aggravate after sun exposure.[1]

Case Report

A 40-year-old man presented with asymptomatic skin lesions over extremities and face for last 2 years. There was no family history of similar lesions.

Cutaneous examination showed numerous slightly hyperpigmented circular plaques with slightly raised hyperkeratotic edges on face and extensor aspects of both the extremities. The lesions varied from 2 mm to 13 mm in diameter. Systemic examination was non-contributory.

Histopathology from the edge of skin lesion showed hyperkeratosis and a parakeratotic columm (cornoid lamella) in the epidermal invagination. At the site of invagination the granular layer was thinned out. There was mild chronic inflammatory infiltrate.

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Discussion

DSAP is characterised by multiple small slightly raised lesions having a hyperkeratotic ridge without a distinct furrow.[2] The lesions are common on sun-exposed sites and extensor aspect of extremities. The disease is common between 2nd to 4th decade, transmitted in an autosomal dominant fashion, and is more frequent in women.[3] It is considered as a premalignant condition and report of squamous cell carcinoma in DSAP is documented.[4] In some cases the lesions may not be found in sun-exposed area.[5]

References

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