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References

1. Savage KJ, Harris NL, Vose JM, Ullrich F, Jaffe ES, Connors JM. ALK-anaplastic large cell lymphoma is clinically and immunophenotypically different from both ALK+ ALCL and peripheral T-cell lymphoma, not otherwise specified: Report from the International Peripheral T-Cell Lymphoma Project. Blood 2008;111:5496–5504.
2. Ferreri AJ, Govi S, Pileri SA, Savage KJ. Anaplastic large cell lymphoma, ALK-negative. Crit Rev Oncol Hematol 2013;85:206–15.
3. Querfeld C, Khan I, Mahon B, Nelson BP, Rosen ST, Evens AM. Primary cutaneous and systemic anaplastic large cell lymphoma: Clinicopathologic aspects and therapeutic options. Oncology (Williston Park) 2010;24:574–87.
4. Doghri R, HadjKacem LB, Houcine Y, Charfi L, Driss M, Kacem K. Prognostic factors of ALK-negative anaplastic large-cell lymphoma: A single-institution experience. Ann Hematol 2018;97:725–726.
5. Bird JE, Leitenberger JJ, Solomon A, Blauvelt A, Hopkins S. Fatal ALK-negative systemic anaplastic large cell lymphoma presenting with disseminated cutaneous dome-shaped papules and nodules. Dermatol Online J 2012;18:5.
6. Niiyama S, Satoh K, Kaneko S, Aiba S, Takahashi M, Mukai H. Zosteriform skin involvement of nodal T-cell lymphoma: A review of the published work of cutaneous malignancies mimicking herpes zoster. J Dermatol 2007;34:68–73.
7. Shiohara J, Koga H, Uhara H, Takata M, Saida T, Uehara T. Herpes zoster histopathologically mimicking CD30-positive anaplastic large cell lymphoma. J Eur Acad Dermatol Venereol 2009;23:618–9.

Prurigo nodularis with cornoid lamellation

Dear Editor,

Prurigo nodularis is a chronic skin condition characterized by multiple firm, itchy nodules typically involving the extensor surface of the extremities. It is a nodular form of lichen simplex chronicus with histopathological features of chronic dermatitis. Cornoid lamellation is a histomorphology involving tiers of parakeratosis invaginating into the epidermis with underlying dyskeratotic cells. It is typically seen in porokeratosis but has been reported in various dermatoses. We describe an interesting case of peno-scrotal prurigo nodularis with characteristic cornoid lamellation.

A 30-year-old atopic man presented with severely itchy, multiple, discrete papulonodular lesions on his scrotum, left thigh and glans penis for 7 years [Figure 1]. Our provisional clinical diagnosis was genital prurigo nodularis. Skin biopsy revealed massive hyperkeratosis, parakeratosis, hypergranulosis, irregular acanthosis, papillary dermal fibrosis and mild perivascular and interstitial lympho-histiocytic infiltrate. [Figure 2a]. In

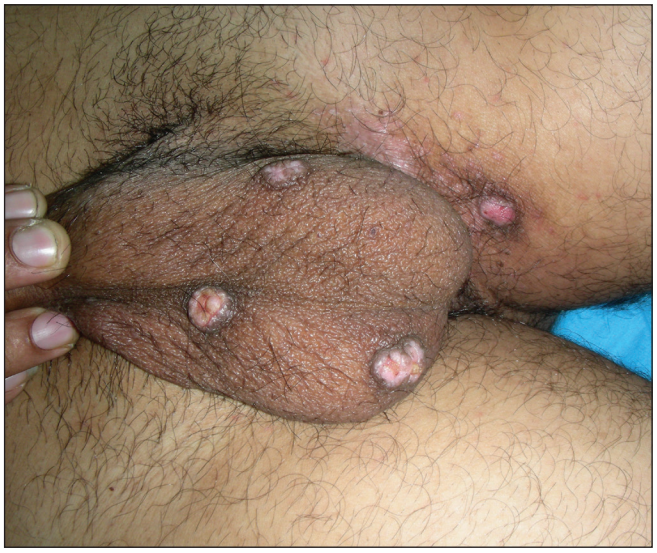

Figure 1: Multiple discrete nodules on the scrotum and left thigh

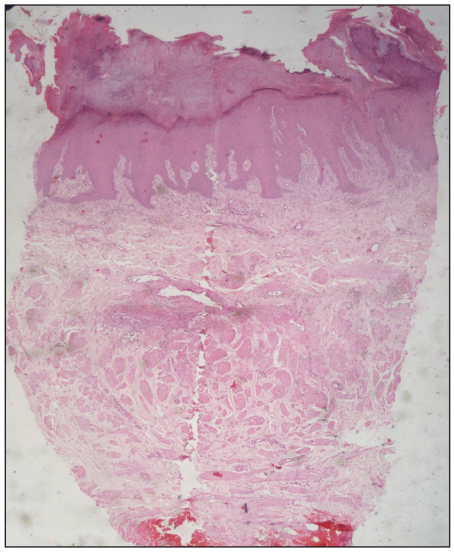

Figure 2a: Massive hyperkeratosis, parakeratosis, irregular acanthosis, papillary dermal fibrosis, increased capillary proliferation in the papillary dermis, a perivascular lymphohistiocytic infiltrate, suggestive of prurigo nodularis (H & E ×20)

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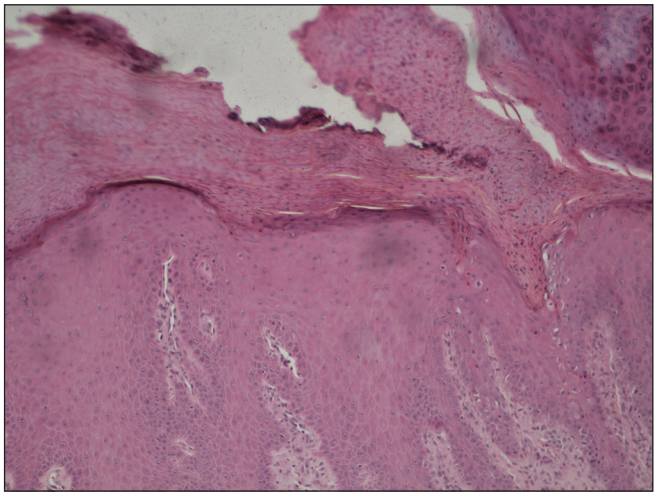

Figure 2b: A vertically oriented parakeratotic column invaginating into the epidermis with underlying dyskeratotic cells suggestive of cornoidlamellation (H & E ×100)

Figure 3: Significant flattening of prurigonodularis lesions after three injections of intralesional triamcinolone acetonide

one focus, parakeratotic column invaginating into the epidermis with underlying dyskeratotic cells was present suggestive of cornoid lamellation [Figure 2b]. Biopsy was consistent with prurigo nodularis but with a conspicuous cornoid lamellation which prompted us to consider verrucous penoscrotal porokeratosis as a differential. The lesions significantly flattened after three intralesional injections of triamcinolone acetonide 5 mg/mL, 0.1–0.3 mL injected per lesion [Figure 3].

Prurigo nodularis is histologically characterized by thick compact hyperkeratosis, focal parakeratosis, hypergranulosis, irregular epidermal hyperplasia, papillary dermal fibrosis with vertically arranged collagen fibres, a superficial perivascular inflammatory infiltrate of lymphocytes, macrophages and sparse eosinophils and neutrophils.[1] Occassionally, epidermal erosions with a characteristic V-shaped configuration or superficial shedding of necrotic keratinocytes may be observed in the upper granular layer.

Cornoid lamellation, first described in 1893 by Mibelli, is characterized by a vertical column of parakeratosis extending obliquely into the epidermis, loss or marked diminution of the granular layer at the point where the parakeratotic column indents the epidermal surface and dyskeratosis and/or vacuolisation of the underlying cells of the stratum spinosum.[2] Cornoid lamellation is typically observed in porokeratosis, where it corresponds to the thread-like scale present at the lesional margin. The designation 'porokeratosis' was originally coined based on the erroneous assumption that cornoid lamellation emerged from the pores of sweat glands.[2]

Cornoid lamellation, however, is not pathognomonic of porokeratosis and may be encountered in several inflammatory and neoplastic dermatoses like lichen planus, psoriasis, viral warts, actinic keratosis, ichthyosis hystrix, Wong-type dermatomyositis, atypical keratosis lichenoides chronica (atypical Nekam's disease), pachyonychia congenita, verrucous epidermal nevus, squamous and basal cell carcinoma.Thus, it is often regarded as one of the 'minor tissue reactions' in the pattern-based diagnostic approach of inflammatory skin disorders.[3]

We were unable to find any report of cornoid lamellation in prurigo nodularis. A case of disseminated superficial actinic porokeratosis having prurigo-like lesions clinically with histopathologic cornoid lamellation has been described.[4] The histopathology in our patient also prompted us to consider verrucous/hyperkeratotic porokeratosis, penoscrotal variant. Joshi et al. have reported 10 cases with porokeratotic epidermal reaction pattern with multiple cornoid lamellae manifesting as pruritic penoscrotal plaques with an ill-defined rough granular surface.[5] They were poorly responsive to topical steroids and flattened with oral isotretinoin 20 mg/day. Our patient showed an excellent response to intralesional steroids, which made us consider prurigo nodularis with cornoid lamellation.

Declaration of patient consent

The authors certify that they have obtained all appropriate patient consent.

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Conflicts of interest

There are no conflicts of interest.

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References

1. Weigelt N, Metze D, Stander S. Prurigonodularis: Systematic analysis of 58 histological criteria in 136 patients. J CutanPathol 2010;37:578–86.
2. Das A, Vasudevan B, Talwar A. Porokeratosis: An enigma beginning to unravel. Indian J DermatolVenereolLeprol 2022;88:291–9.
3. Biswas A. Cornoidlamellation revisited: Apropos of porokeratosis with emphasis on unusual clinicopathological variants. Am J Dermatopathol 2015;37:145–55.
4. Kang BD, Kye YC, Kim SN. Disseminated superficial actinic porokeratosis with both typical and prurigonodularis-like lesions. J Dermatol 2001;28:81–5.
5. Joshi R, Mehta SG. Pruritic porokeratoticpeno-scrotal plaques: Porokeratosis or porokeratotic epidermal reaction pattern? A report of 10 cases. Indian J DermatolVenereolLeprol 2014;80:24–8.

A case of erythema elevatum diutinum associated with peripheral ulcerative keratitis

Dear Editor,

A 61-year-old Chinese man presented with a 15-year history of painful skin lesions on the face, back, hands, elbows, buttocks and knees [Figure 1]. Lesions became exacerbated in cold weather. Several lesions had resolved spontaneously with subsequent intermittent recurrence at the same sites. He complained of recurrent ocular hyperemia and progressively blurred vision. Dermatologic examination showed purple-red, firm papules and plaques on the palms and dorsal aspects of hands, elbows, buttocks, knees and feet. In the right eye, slit-lamp examination showed corneal conjunctivalisation with conjunctival and episcleral hyperemia. There was a broad-based pseudopterygium that inserted onto the peripheral cornea from conjunctiva of lower right eyelid and conjunctival scar formation, leading to trichiasis and symblepharon [Figure 2]. Laboratory findings showed an elevated serum IgA level (monoclonal IgA λ-type). The histopathology of the lesions on the thigh revealed diffuse neutrophils, nuclear dust, leukocytoclastic vasculitis of the superficial and mid-dermal vessels [Figure 3]. Therefore, a diagnosis of erythema elevatum diutinum (EED) with peripheral ulcerative keratitis (PUK) was established based on the clinical and histopathological features.

Erythema elevatum diutinum is a rare form of neutrophilic dermatoses which is characterised by the presence of mature neutrophilic infiltration in the skin and other organs, with

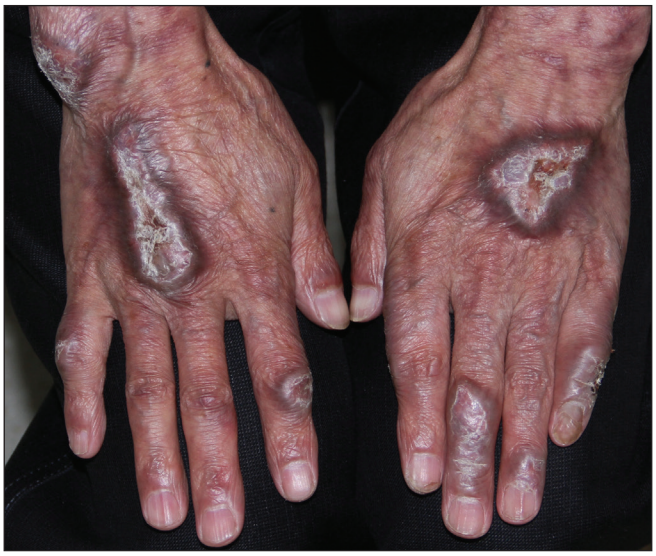

Figure 1a: Purple-red, firm papules and plaques on the dorsal aspects of hands

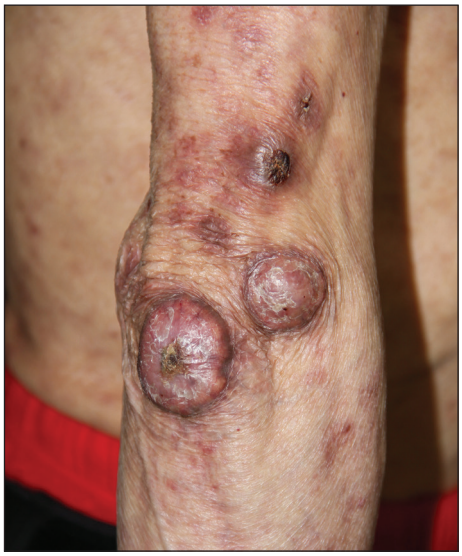

Figure 1b: Purple-red, firm papules and plaques on the dorsal aspects of elbow

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