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E-CASE REPORT

Dermoscopy of Disseminated Superficial Actinic Porokeratosis

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KEYWORDS
Disseminated superficial actinic porokeratosis;
Porokeratosis;
Dermoscopy

Abstract We present a series of 6 cases of disseminated superficial actinic porokeratosis and describe their dermoscopic features.

Dermoscopy is a noninvasive in vivo technique that is useful as a tool for the diagnosis and follow-up of porokeratosis. This condition has specific dermoscopic features that were observed in our series of cases and that are consistent with reports in the international literature.

PALABRAS CLAVE
Poroqueratosis actínica superficial diseminada;
Poroqueratosis;
Dermatoscopia

Dermatoscopia de la poroqueratosis actínica superficial diseminada

Resumen Presentamos una serie de 6 casos de poroqueratosis actínica superficial diseminada en los cuales se describen las características dermatoscópicas halladas en cada uno de ellos.

La dermatoscopia es una técnica no invasiva in vivo útil como herramienta diagnóstica y de seguimiento en la poroqueratosis ya que se describen elementos dermatoscópicos específicos de esta entidad observados en nuestra serie de casos, que concuerdan con lo comunicado en la literatura internacional.

Introduction

Porokeratosis (PK) is a group of chronic, progressive disorders of keratinization that includes several subtypes with a broad clinical spectrum.[1]

Five clinical variants of PK have been described based on different patterns of distribution. PK of Mibelli, disseminated superficial PK, linear PK, punctate palmoplantar PK, and disseminated superficial actinic PK (DSAP).[2,3] An eruptive form of PK with a rapidly progressive clinical course has also been described, with lesions affecting the entire skin surface. This form of porokeratosis has been associated with malignancies, immunosuppression, and pro-inflammatory states, although the small number of reported cases makes relationships difficult to demonstrate.[4] Other proposed variants include malignant disseminated PK, PK plantaris discreta, and reticular PK.[5]

DSAP is the most common clinical subtype.[2,6,7] It is a chronic, autosomal dominant disease characterized by

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Table 1 Clinical details of the case series.

Patient	Sex	Age, y	Phototype	Relevant past history	Disease duration	Symptoms	Site	Clinical findings	Dermoscopy
1	F	45	II	No	5 years	Pruritus	Sun exposed areas of upper limbs	Multiple, well-defined, slightly erythematous papules with peripheral enhancement. Fine pigmented desquamation	Fig. 1A
2	M	37	III	Occupational sun exposure	6 months	No	Sun exposed areas of lower limbs	Same clinical features as patient 1	Fig. 1B
3	F	51	III	Smoker	Unknown	Pruritus	Sun exposed areas of upper and lower limbs	Erythematous-to-brownish papules with fine scales and pale central area	Fig. 2A
4	M	62	II	Asthma	18 months	No	Sun exposed areas of both lower limbs	Erythematous and brown plaques with fine peripheral scales	Fig. 2B
5	F	55	II	No	2 years	No	Upper limbs and upper back	Brown-to-grey plaques of 1-cm diameter, with a raised scaly grey border and a hypopigmented central area	Fig. 3A
6	F	58	II	No	Unknown	No	Sun exposed areas of the limbs	Same clinical features as patient 4	Fig. 3B

Abbreviations: F, female; M, male.

multiple erythematous-to-brownish papules and annular plaques with a well-defined hyperkeratotic border around a sometimes atrophic central area.[5,8] Lesions usually start to appear in adolescence, in exposed areas; complete penetrance is reached in the third or fourth decade of life. The disease is rare in black individuals and in the elderly.[1,5] Histopathology shows a narrow column of parakeratotic cells, the cornoid lamella, extending through the stratum corneum. This correlates clinically with the raised hyperkeratotic border.[2,6]

The dermoscopic features of DSAP suggest the diagnosis. We describe a series of 6 patients in which we detected several dermoscopic features associated with DSAP that are useful for diagnosis and follow-up.

Case descriptions

The clinical findings of each case are summarized in Table 1. The following dermoscopic alterations were observed: in case 1, a central area of atrophy was surrounded by an annular border with scales (Fig. 1A); in case 2, the lesions presented vascular structures and a hyperkeratotic border (Fig. 1B); brownish dots and central atrophy were observed in case 3 (Fig. 2A); central hairpin vessels were seen crossing the plaques in case 4 (Fig. 2B); in case 5 there was a scar-like area (Fig. 3A); and in case 6, irregular vessels were visible in a central area of atrophy surrounded by a hyperkeratotic border (Fig. 3B).

Biopsy was performed in all patients to confirm the diagnosis of DSAP. At the time of writing, the clinical and dermoscopic follow-up had been of 18–36 months.

Discussion

Porokeratosis is a group of disorders in which there is a disturbance of keratinization. DSAP typically affects sun-exposed areas, suggesting that UV radiation may be the most important extrinsic factor.[3,6]