Porokeratosis (PK) is a disorder of clonal hyperproliferation of keratinocytes. It has several clinical manifestations characterised by variably sized papules or plaques with a fine peripheral keratotic rim and central atrophy accompanied by a histological finding of cornoid lamella (1).

Cutaneous lesions vary in their appearance and distribution. Disseminated superficial actinic porokeratosis (DSAP) is characterised by numerous papules and plaques distributed over sun-exposed sites. Coexistence of disseminated superficial and disseminated warty PK is very rare (2).

A recent review on DSAP found no published controlled trials evaluating its treatment (3). The knowledge base for treatment is derived exclusively from case reports. To our knowledge, none of the published cases of disseminated superficial and warty PK describe the results of systemic treatment with acitretin.

CASE REPORT

An 86-year-old man presented to the University of Tartu Dermatology Clinic in late 2012 with a 10-year history of a persistent progressive eruption on his gluteal region, thighs and legs. He was treated for presumed verrucous warts with salicylic acid ointment and cryotherapy without success.

He reported that the eruption first appeared on the dorsal aspect of his foot in the form of 1–2 cm plaques. The patient denied any pruritus. However, extensive hyperkeratotic plaques over the ankles caused him considerable discomfort. There were no similar familial cases.

On clinical examination, the patient appeared well. A small (not tender, freely moveable) lymph node was palpable in the left axillary region. Cutaneous examination revealed: (i) several plaques (4–6 cm in diameter) with gross hypertrophic verrucous surfaces confined to the periphery (Fig. 1A) on both legs; (ii) multiple brownish to pink annular macules with raised peripheral ridges (2 mm to 7 cm), with an atrophic and desquamative centre and well-demarcated keratotic and filiform border on the extensor surfaces of the thighs, and on the extensor surface of the patient’s right arm; (iii) brownish verrucous annular plaques in the gluteal region (bilaterally).

A biopsy was taken from 2 types of lesions: one from the margin of a delicate annular plaque on the left shin, and one from the well-defined verrucous margin of a lesion on the patient’s left foot. Histological examination confirmed the diagnosis of PK in both specimens (Fig. S1). PK has also been reported in association with dermal amyloid deposition as a result of apoptosis of keratinocytes (5), and this was also documented in this case.

A comprehensive metabolic screening was normal. Abdominal ultrasonography showed a left polycystic kidney but no enlarged lymph nodes in the abdominal or pelvic cavities. Chest radiograph was normal. Human papilloma virus test (PCR based) from the lesions on the foot was negative.

A complete blood count revealed marked changes in the white blood cell count (WBC; 21.53 (normal range

Fig. 1. Clinical images of some of the skin lesion at the time of diagnosis (A) and after 8 weeks treatment with acitretin (B).
In conclusion, coexistence of 2 or more variants of PK in a single patient can occur and whether the different morphological forms of PK (giant, hypertrophic verrucous) consist different forms of PK or a variation on the clinical spectrum of disease warrants further research. Evidence for the treatment of PK is equivocal. Based on our experience in this case, systemic treatment with acitretin (especially for the disseminated warty forms of PK) should be considered as an option.

The authors declare no conflicts of interest.

REFERENCES