ORIGINAL RESEARCH PAPER

Dermatology

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POROKERATOSIS MASQUERADING AS BCC

Dr. Kavya Rajeev*

Junior Resident, Department of Dermatology, Venereology and Leprosy, Sree Balaji Medical College and Hospital, 7, CLC works road, Chromepet, Chennai- 600044, Tamil Nadu, India. *Corresponding Author

Dr. Sowbaghya P T

Junior Resident, Department of Dermatology, Venereology and Leprosy, Sree Balaji Medical College and Hospital, 7, CLC works road, Chromepet, Chennai- 600044, Tamil Nadu, India.

ABSTRACT

Porokeratosis represents a rare keratinisation disorder characterised by annular lesions with an atrophic centre and thin raised border. A porokeratosis is a clonal expansion of keratinocytes which differentiate abnormally. The hallmark histological feature is the cornoid lamella. The etiology is still unclear. Diabetes Mellitus, Crohn's disease, HIV infection are few notable associations. There are various clinical variants of porokeratosis. Development of malignancy in few variants is a concern. Topical corticosteroids, retinoids and 5-Flurouracil form the first line of treatment.

INTRODUCTION

Porokeratosis was first described by Neumann in 1875[1] and later Mibelli coined the term Porokeratosis due to the involvement of eccrine ostia. Porokeratosis has slight male preponderance. Abnormalities in the mevalonate pathway initiates porokeratosis. Porokeratosis is classified into localised and generalised forms. UV-exposure, radiotherapy, immunosuppression are few triggering factors.[2] The lesion can present anywhere in the body. In this case report we discuss a rare presentation of porokeratosis.

Case Report

26-year- old female came with complaints of single dark raised lesion over the left lower back since 4 years. It was initially small in size and gradually increased in size. It was associated with intermittent itching. No history of pain, trauma, topical application of irritants, fever, drug intake prior to the onset of lesions. No lesions elsewhere in the body.

On examination: Single hyperpigmented plaque of size 5x3 cm with raised border and scaly atrophic centre noted over left lumbar region.

Figure 1

4mm skin punch biopsy was taken from the margin of the lesion and sent for histopathological examination.

Histopathology revealed: cornoid lamella , a diagnosis of porokeratosis was made.

Differential considered in this case was BCC

DISCUSSION

Porokeratosis is a complex keratinisation disorder with malignant potential. Germline mutation in one allele of a gene involved in mevolante pathway and somatic mutation(two hit hypothesis) leads to the development of porokeratosis.[3] Based on the variants the clinical features differ. The clinical variants are Porokeratosis of Mibelli, Linear porokeratosis, Punctate palmoplantar porokeratosis, Genital porokeratosis, ptychotrophic porokeratosis, Disseminated superficial actinic porokeratosis, Disseminated superficial porokeratosis, Disseminated palmoplantar porokeratosis, Systematised linear porokeratosis and CDGAS syndrome. The classical presentation is annular plaque with thin keratotic border. The hallmark feature is the presence of cornoid lamella, a column of parakeratotic keratinocytes. Cryotherapy, topical corticosteroids, 5-Fluorouracil form the first line of therapy and systemic retiniods form the second line therapies. Differential diagnosis include psoriasis, hypertrophic lichen planus, lichen simplex chronicus, cutaneous TB and rarely mimic BCC[4]

CONCLUSION

Porokeratosis has heterogenous presentation with few variants exhibiting malignant potential hence a case of porokeratosis should be thoroughy evaluated.

Legend To The Figures:

Figure 1 showing -Single hyperpigmented plaque of size 5x3 cm with raised border and scaly atrophic centre noted over left lumbar region.

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