**APRIL ANSWERS**

**QUESTIONS**

1. What is the diagnosis?
   - Porokeratosis is a clonal disorder of keratinization characterized by one or more atrophic patches, surrounded by a distinctive hyperkeratotic ridge-like border. There are five clinical variants of porokeratosis including classic POM, disseminated superficial actinic porokeratosis (DSAP), porokeratosis palmaris et plantaris disseminata (PPPD), linear porokeratosis, and punctate porokeratosis.

2. What is the possible complication?
   - There is a 7–11% risk of porokeratosis skin lesions developing basal cell carcinoma or squamous cell carcinoma. Linear porokeratosis and giant lesions have the highest chance of malignant transformation.

3. What investigation can be done?
   - Histopathology will show cornoid lamellae which are an angulated tier or column of parakeratotic cells. Keratinocytes exhibiting cytoligical atypia can be seen at the base of the parakeratotic column, and there is usually a moderately dense lymphocytic infiltration with dilated capillaries in the underlying papillary dermis.

4. What would be your treatment?
   - Extensive lesions may require surgical excision. For other therapeutic options for POM, whilst local destructive therapies such as cryotherapy, electrodesication and curettage, and carbon dioxide laser ablation are also effective treatment modalities. Extensive lesions may require surgical excision.

5. What are the possible risk factors for this skin disorder?
   - Porokeratosis includes genetic inheritance, ultraviolet radiation and immunosuppression.

**ANSWERS**

1. The diagnosis is porokeratosis of Mibelli (POM). Porokeratosis is a clonal disorder of keratinization characterized by one or more atrophic patches, surrounded by a distinctive hyperkeratotic ridge-like border. There are five clinical variants of porokeratosis including classic POM, disseminated superficial actinic porokeratosis (DSAP), porokeratosis palmare et plantaris disseminata (PPPD), linear porokeratosis, and punctate porokeratosis.

2. Possible risk factors for porokeratosis include genetic inheritance, ultraviolet radiation and immunosuppression.

3. An incisional (or excisional if the lesion is small) skin biopsy at the edge of the lesion can be performed. Histopathology will show cornoid lamellae which are an angulated tier or column of parakeratotic cells. Keratinocytes exhibiting cytological atypia can be seen at the base of the parakeratotic column, and there is usually a moderately dense lymphocytic infiltration with dilated capillaries in the underlying papillary dermis.

4. Topical 5-fluorouracil and imiquimod 5% cream are well documented medical therapeutic options for POM, whilst local destructive therapies such as cryotherapy, electrodesication and curettage, and carbon dioxide laser ablation are also effective treatment modalities. Extensive lesions may require surgical excision.

5. There is a 7–11% risk of porokeratosis skin lesions developing basal cell carcinoma or squamous cell carcinoma. Linear porokeratosis and giant lesions have the highest chance of malignant transformation.

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