Institute of Experimental Morphology, Pathology and Anthropology with Museum
Bulgarian Anatomical Society

Acta morphologica et anthropologica, 22
Sofia ● 2015

Psoriasiform Keratosis – a Case Report

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Psoriasiform keratosis is a unique clinico-pathological entity which was first reported in 2007. To date, no more than 30 cases have been reported worldwide. The condition is presented by a solitary keratotic papule or plaque with typical psoriasis histology. Obligatory, the patients have no pre-existing and current skin changes suggestive for psoriasis. We describe a 43-year-old man with a single scaly yellow-to-gray lesion localized to his body. Focal psoriasiform inflammatory pattern was found on routine histology. He claimed to have no personal or family history of psoriasis. Based on patient's history and clinical manifestation we raise the hypothesis that psoriasiform keratosis should be considered a lesion sui generis rather than a rudimentary manifestation of psoriasis.

Key words: psoriasis, keratosis.

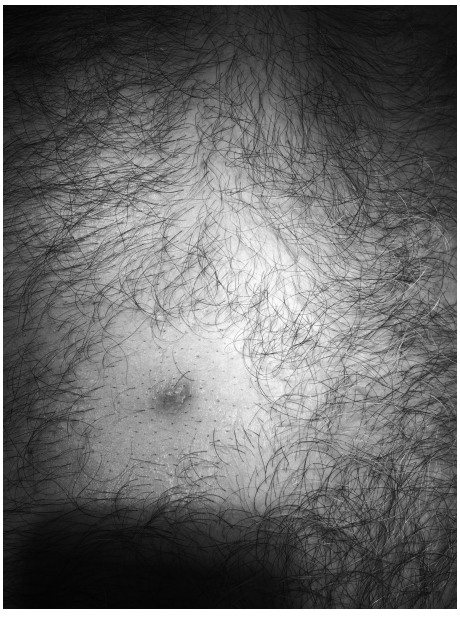

Fig. 1. A scaly erythematous papule with elevated borders

Introduction

In 2007 Walsh et al. [5] described a new entity that clinically represents a solitary scaly, erythematous plaque, which showed histological features of psoriasis [5]. The term "psoriasiform keratosis" was coined for these peculiar lesions, which seem to be exceptionally rare. To date, no more than 30 cases have been reported worldwide. Herein, a male patient with psoriasiform keratosis, localized on the body, is described.

Case Report

A 43-year-old Caucasian man complaining of a small lesion on his presternal zone with a 3-week duration. The lesion was intermittently itchy, and grew peripherally at

a very slow pace. The patient had neither personal nor family history of psoriasis. On physical examination a single one-centimeter in diameter erythematous scaly papule with elevated borders was presented (**Fig. 1**). Antibiotic and mild-potent corticosteroid preparations were used with no effect for the last 3 weeks. Mycological and bacterial cultures were negative. Histopathological examination showed papillomatosis, psoriasiform acanthosis, focal agranulosis, vacuolated and pale superficial keratinocytes and

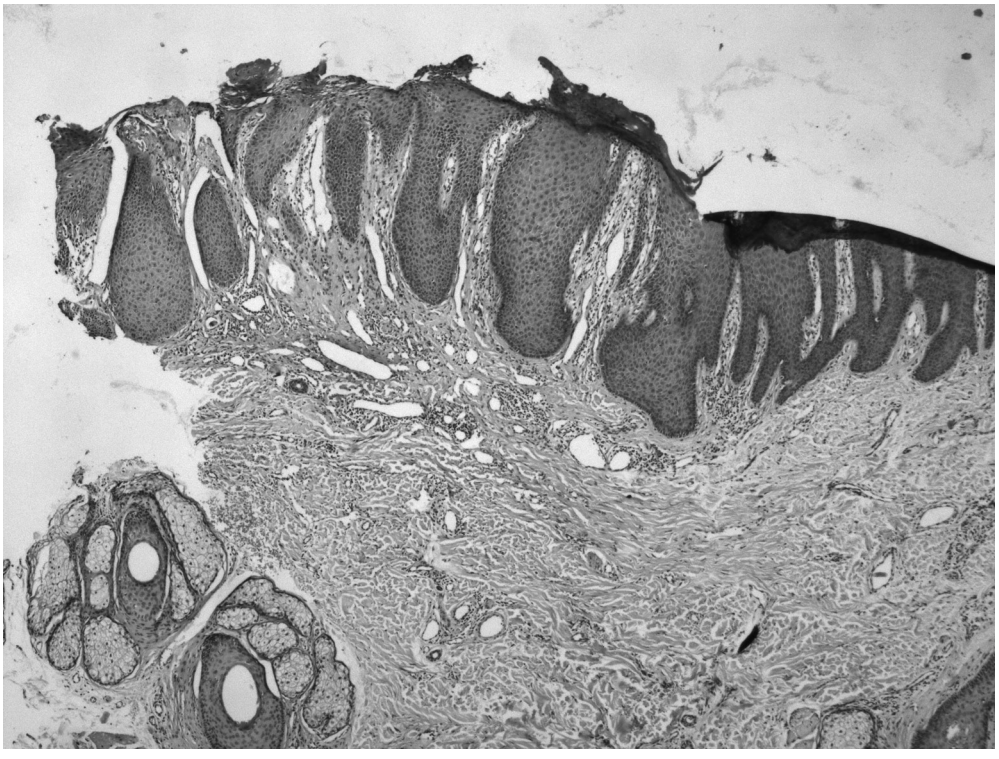

Fig. 2. Focal parakeratosis, lack of granular cell layer, psoriasiform acanthosis, reduction of suprapapillary segments (HE × 100)

suprapapillary epidermal atrophy (**Fig. 2**). No atypical keratinocytes were present. The papillary dermis was filled-in with mild perivascular lymphocytic infiltrate. Ectatic capillaries were seen in the subepidermal segment of the dermis. Based on the clinical and histology findings the diagnosis of psoriasiform keratosis was concluded. The patient was advised to undergo a radical excision, which was scheduled duly.

Discussion

Psoriasiform keratosis is a rare clinic entity. It is characterized by solitary, scaly keratotic papule, or plaque mainly located on the extremities. Other sites that can be involved are scalp, neck, shoulders, and back [3]. Usually the lesions evolve in 6 to 7 months. They can be associated with burning sensation, itch or mild pain. All patients are in good general health. Slight men preponderance is noticed. There is no personal or family history of psoriasis. The etiopathogenesis of the disease remains unknown.

Clinically, most lesions are averagely less than one centimeter. They are dome-shaped, scaly and yellow-to-gray. The diagnosis is based on histopathological findings, which are unrecognizable from psoriasis. Focal segmental parakeratosis, lack of granular cell layer, regular acanthosis and suprapapillary reduction is typical for the disease. Sometimes neutrophilic microabscesses and Kogoj pustules can be found. Vascular dilatation and lymphocytic chronic inflammation are usually present in the superficial dermis. Periodic acid-Schiff (PAS) stain should be performed to rule out yeast or dermatophyte infection [1]. Recently, human papilloma virus 6 was verified by tissue polymerase chain reaction in a 74-year-old woman with a typical psoriasiform keratosis on the left arm [4]. Interestingly, this finding did not correspond to any nuclear inclusion bodies or specific koilocytes in the epidermis of the tissue samples on routine HE staining

Psoriasiform keratosis is usually refractory to topical modalities [2]. Destructive chemical substances are not useful, together with electrodesiccation and cryotherapy. Radical surgical excision is a first-line therapy with minimal relapse rate.

In conclusion, we described the first case of psoriasiform keratosis in Bulgaria. The lesion shows very rare localization and typical therapeutic resistance. Based on patient's personal history and clinical manifestation we believe psoriasiform keratosis should be considered a lesion sui generis rather than a rudimentary manifestation of psoriasis.

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