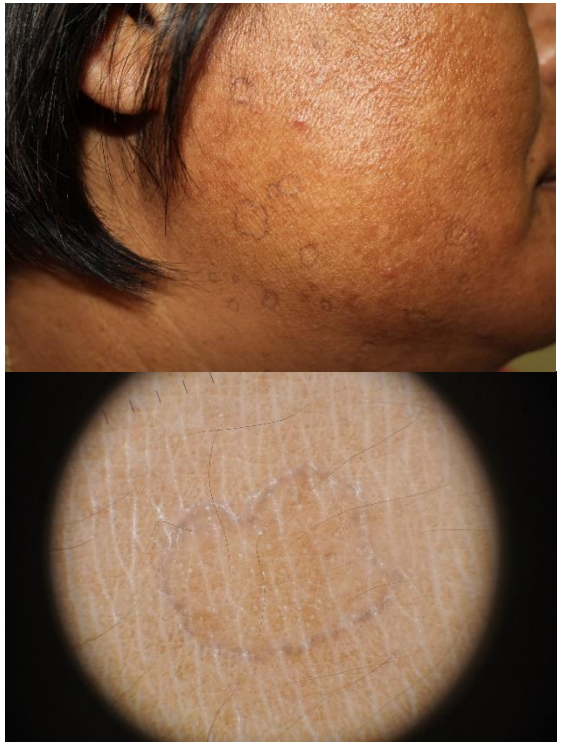
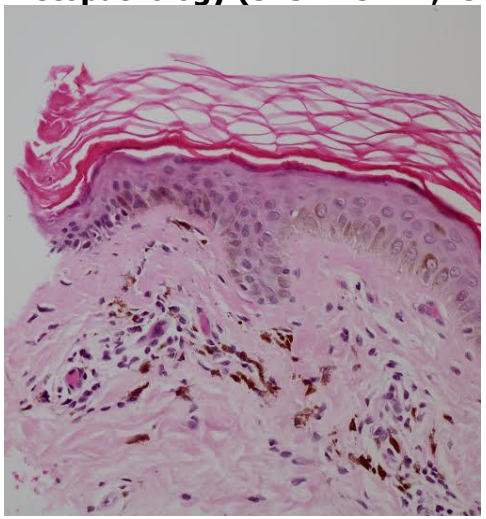
Case 21
A 45-year-old Thai woman from Nakornsawan
Chief complaint: Asymptomatic rashes on face and both forearms for 2 years



Present illness: She presented with asymptomatic skin lesions on her face and both forearms for 2 years. She denied any previous treatments. The patient had no family history of cutaneous disease.
Past history
No significant past medical history, including skin disease
No history of drug or food allergy
No history of herbal or traditional medicine and chronic radiation
No family member has similar lesions
Occupation: housewife
Skin examination
Multiple discrete small slightly atrophic brownish patches with thread-like elevated border, distributed symmetrically on face and extensor area of both forearms
Dermoscopy examination
A continuous, dark brown outline on the border of the lesions, demarcating a homogeneous brownish region
Histopathology (S15-22971A, left arm)



-Patchy lichenoid infiltrate of melanophages, associated with cornoid lamella
-Focal epidermal atrophy
Diagnosis: Disseminated superficial actinic porokeratosis
Treatment:
-Calcipotriol (Daivonex) 50mcg/gm apply lesions twice daily
-Sun protection
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Discussion:

The porokeratosis is known as a group of chronic disorders which has an abnormality in epidermal keratinization[1,2]. There are several clinical variants recognized[1], each with own specific characteristics in morphology, distribution and clinical course[3]. However, histologically, each variant shares the common hallmark which is called "cornoid lamella"[3], a column of parakeratotic cells in the stratum corneum corresponding to the raised thread-like border clinically[4].

Disseminated superficial actinic porokeratosis (DSAP) is the most common form of the porokeratoses[3]. Initial lesions are characterized by skin-colored, pink or brown keratotic papules. Later on, they become demarcated annular lesions consisting of an atrophic centre bordered by a thread-like elevated ridge which expands centrifugally. Lesions are often asymptomatic or mildly pruritic and predominantly on the extensor surfaces of the extremities, especially the shins and extensor forearms. DSAP usually appears during the third and fourth decade of life[2,5]. Despite its occurrence being related to sunlight exposure, only 15% of patients have lesions affected on their faces[3].

Malignant transformation, especially squamous cell carcinoma, has been reported with an overall incidence of 7.5% to 11% among all of the clinical variants[6,7]. However, there are only few reports of malignant change in DSAP when compare to other variants[8].

A great number of therapies for DSAP have been proposed, unfortunately, most of the treatments are unsatisfactory[2]. Treatment with cryotherapy, topical 5-Fluorouracil, topical vitamin D-3 analogues and retinoids is typically considered. Even though cryotherapy is the first line treatment, it can cause pain and scars[2]. Lately, a novel study reported that diclofenac sodium 3% gel succeeded in protecting against disease progression when compared to the global lesion count[2]. Due to the possibility of malignant change induced by UV, it is necessary to emphasize to all patients about sun avoidance and protection[3].

References

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