ANSWER TO PHOTO QUIZ (PAGE 346)

SKIN LESIONS IN A DIABETIC PATIENT

DIAGNOSIS

Clinical and histopathological findings were consistent with the diagnosis of acquired perforating dermatosis (APD). Topical treatment with topical tretinoin 0.5% cream was commenced and a prompt review with the nephrology team was arranged.

Perforating diseases are defined by the transepidermal elimination of materials from the dermis, including elastic fibres, collagen, and keratin. APD characteristically presents in adulthood in association with systemic disease, most notably DM and chronic renal disease. Pathogenesis remains uncertain but a possible relationship to mild superficial trauma (e.g., chronic rubbing or scratching) has been suggested and is supported by the frequent linear arrangement of lesions (Koebner phenomenon) and the improvement of lesions with antipruritic treatments.[1-3] Clinically, lesions most commonly present as mildly erythematous hyperkeratotic or crateriform papules and nodules with a predilection for the follicular unit.[4] They are usually pruritic and favour the extensor surface of the legs, the upper extremities, and the trunk.[2,4] Regarding taxonomy, whether APD can be classified as an acquired form of one of the classical perforating dermatoses (reactive perforating collagenosis, elastosis perforans serpiginosa, perforating folliculitis, or Kyrle's disease) or as a variant remains controversial.[2] In addition, the terms 'acquired reactive perforating dermatosis' and 'Kyrle's disease' are often used interchangeably in the literature as a synonym of subtype of APD.[1,3] Histological findings are variable and may include epidermal invagination, dilated or cystic follicles, basophilic necrotic debris and ortho or parakeratotic plugs, inflammatory infiltrate, and altered collagen or elastic fibres in the superficial dermis.[1,4]

Differential diagnoses include other disorders characterised by nodules or papules with keratotic plug or crusts, such as prurigo nodularis and prurigo simplex, folliculitis, and multiple dermatofibromas or keratoacanthomas.

Regarding treatment, general measures include avoiding ongoing trauma and addressing pruritus. Special consideration should be given to identifying and treating any coexisting underlying disease. Topical and intralesional corticosteroids and oral antibiotics have shown inconsistent results. The beneficial effects of topical and systemic retinoids, oral allopurinol, and narrow band UVB and UVA phototherapy have been described in several case reports and case series. Combination treatment, rather than monotherapy, appears to result in more favourable outcomes.[3]

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