the fifth to sixth decade of life. Initially thought to be a transient condition, persistent cases exist. The cause is uncertain, but UV radiation, radiation therapy, xerosis, hot environmental conditions, and increased sweating have been implicated.

The present findings suggest that increased sweating and dysfunction of the postganglionic sympathetic fibers that innervate the eccrine glands may cause transient acantholytic dermatosis and secondary hyperhidrosis. Physicians caring for patients with spinal cord trauma should be aware of this possibility to avoid erroneous alternative diagnoses such as drug eruptions or viral exanths.

Richard W. Hempstead, MD
Nancy L. Hempstead, BS
Leon M. Edelstein, MD

Correspondence: Dr Hempstead, 509 S Main St, Ste B, Las Cruces, NM 88001 (rw hempstead@gmail.com).

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Clinical and Dermoscopic Features of Porokeratosis of Mibelli

Porokeratosis is a rare, genetically determined disorder of epidermal keratinization characterized by lesions with keratotic borders corresponding histopathologically to compact columns of parakeratotic cells called cornoid lamellae that extend through the stratum corneum. The clinical variants include porokeratosis of Mibelli (PM), disseminated superficial actinic porokeratosis, linear porokeratosis, porokeratosis palmaris, plantaris et disseminate, and punctate porokeratosis.

Report of a Case. A 15-year-old boy presented with an area of asymptomatic dermatosis on the anterior right forearm that had first developed 12 years earlier and enlarged slightly over the years. No family history of porokeratosis was reported. Clinical examination revealed whitish-red round papules that coalesced into an irregular plaque and single papules, the overall patch extending 3.5 cm in length on the forearm. The area of plaque and papules had an annular appearance with whitish borders. It was cleaved by a central furrow with central, slightly raised whitish-red portions on either side of the furrow (Figure 1). Clinical differential diagnoses included patch dermatitis, actinic keratosis, and Bowen disease.

Dermoscopic evaluation of the lesion (Figure 2) revealed a thin, whitish rim surrounding the entire perimeter of the affected area; in some sections of this perimeter, the typical brown globules and/or dots conjoined to form a continuous line inside a whitish rim. In the central portion, a diffuse whitish-brown pigmentation with brown globules and/or dots was seen. Moreover, we observed dotted and linear vessels, regular and irregular, straight and curved, partially obscured by erythematous patches.

A 5-mm punch biopsy specimen of the peripheral hyperkeratotic ridge was obtained, and histopathologic examination showed parakeratotic columns within the stratum corneum of the epidermis, horny cells with pyknotic nuclei (cornoid lamella), and cytoplasmic features of premature keratinization. The underlying granular layer was thin or absent (Figure 3). No lymphoid infiltrate was present in the dermis. Gram stain highlighted the blue cornoid lamellae (Figure 3B). Based on clinicodermoscopic and histopathologic assessment, the lesion was diagnosed as PM.

Comment. Porokeratosis of Mibelli was first described by Mibelli in 1893 as single or multiple annular and gy-
rate plaques with central atrophy and elevated keratotic borders containing a longitudinal furrow.² It usually has onset in childhood but may appear at any age, especially in nonhereditary cases, with unilateral localized lesions. Various clinical types of PM were later described.¹,²

Our case involved lesions clinically similar to those originally described by Mibelli; in fact, even in his patient, the lesions were whitish-red and bordered by an elevated ridge.³ Dermoscopically, our case clearly displayed the thin, whitish peripheral rim corresponding histopathologically to cornoid lamella as reported in the literature.³⁻⁵ The typical brown globules and/or dots seen within the whitish rim are histopathologically associated with tiny melanophages in the subepidermal region (Figures 2 and 3) and probably represent their postinflammatory accumulation.³ Moreover, red dots and red lines suggest the vascular pattern seen in atrophic and inflammatory skin.⁶

Use of dermoscopy improves our ability to recognize the hyperkeratotic border, which may aid in the accurate diagnosis of PM and exclude patch dermatitis, actinic keratosis, and Bowen disease, conditions that may clinically mimic PM. In conclusion, the peripheral whitish rim represents the morphologic hallmark of porokeratosis, an essential pathognomonic dermoscopic feature for its diagnosis.

Correspondence: Dr Pizzichetta, Division of Medical Oncology C—Preventive Oncology, Centro di Riferimento Oncologico, Via F. Gallini 2, I-33081 Aviano, Italy (pizzichetta@cro.it).

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Progression of Undiagnosed Cutaneous T-Cell Lymphoma During Efalizumab Therapy

Report of a Case. A 32-year-old man presented with a 2-year history of a pruritic, erythematous dermatitis. A skin biopsy was performed, and he was diagnosed with psoriasis. Treatment was administered with topical corticosteroids, acitretin, UV-B twice per week, and efalizumab, 80 mg, subcutaneous injections each week for 4 months without success. Within 3 months of stopping efalizumab therapy, he developed tumors on his face and ears and presented to the university clinic for evaluation. Other physical findings included alopecic scalp plaques, erythroderma sparing skin folds, palmar and plantar desquamation, erythematous plaques on his back, and no palpable lymphadenopathy.