Porokeratosis of Mibelli: A New Indication for Photodynamic Therapy?

To the Editor:

Porokeratosis is a skin keratinization disorder that gives rise to a number of clinical variants; the underlying disorder can be acquired or hereditary. Clinically, it presents as a macule or annular plaque characterized by a central atrophic patch surrounded by a clearly defined hyperkeratotic border. Histology shows a compact parakeratotic area that had grown gradually over 2-3 years. The solitary, erythematous, rounded plaque measuring 4 × 3 cm had well defined margins and was covered by a whitish scale (Fig. 1). The results of a skin biopsy revealed cornoid lamellae with no signs of cellular atypia (Fig. 2). On the basis of both the clinical examination and histology report, a diagnosis of porokeratosis of Mibelli was established. Because of the size and location of the lesion, photodynamic therapy (PDT) was proposed as a good therapeutic option. A cream containing methyl 5-aminolevulinate (MAL) was applied to the lesion, which was then covered with occlusive dressings for 3 hours. The cream used was Metvix. Upon removal of the dressings, the whole surface of the lesion was observed to emit intense red fluorescence under ultraviolet light. The lesion was then exposed to red light from an LED lamp (Aktilite, 37 J/cm²) for 9 minutes. Two weeks later, the area of treated skin was ulcerated, perhaps as a result of exposure of the lesion to sunlight a few hours after the PDT session, the lesion had almost completely resolved and local therapies were prescribed. Three months after treatment; a new session of PDT was therefore ruled out standing, or linear lesions and those that present in elderly

References


Porokeratosis de mibelli, ¿una nueva indicación de la terapia fotodinámica?

To the Editor:

Porokeratosis is a skin keratinization disorder that gives rise to a number of clinical variants; the underlying disorder can be acquired or hereditary. Clinically, it presents as a macule or annular plaque characterized by a central atrophic patch surrounded by a clearly defined hyperkeratotic border. Histology shows a compact parakeratotic column known as a cornoid lamella. The various clinical forms of the disease are defined by the number and distribution of the lesions: porokeratosis of Mibelli, disseminated superficial actinic porokeratosis, linear porokeratosis, porokeratosis palmare et plantaris disseminata, and punctate porokeratosis. Although the lesions are benign, some of their characteristics are associated with a greater risk of malignant transformation, hence the importance of deciding how to approach these lesions and knowing the different therapeutic options available.

We report the case of an 82-year-old woman with no relevant personal medical history, who visited our department with a skin lesion on the anterior aspect of her left leg that had grown gradually over 2-3 years. The solitary,
or immunocompromised patients have the greatest risk of malignant transformation. Reported neoplasms, in order of frequency, are Bowen disease, epidermoid carcinoma, and basal cell carcinoma. Because of the risk of malignancy, it is important to consider the best approach to take when presented with this dermatosis and to know the different therapeutic options available.

The fact that many different therapies are used is indicative of the lack of an ideal treatment that is safe and effective; each case should therefore be evaluated on an individual basis. In the case of multiple, disseminated lesions, the most appropriate approach may be watchful waiting and biopsy of the lesions in which malignant transformation is suspected. Usual treatments include the following: calcipotriol, tacalcitol, 5-fluorouracil, imiquimod, topical and systemic retinoids, laser therapy, cryotherapy, dermabrasion, and surgical excision. PDT is approved for the treatment of actinic keratosis, superficial and nodular basal cell carcinoma, and Bowen disease. Its use has recently been extended to a number of infectious and inflammatory skin disorders and certain cancers; the results reported to date indicate varying degrees of efficacy. PDT has been used to treat porokeratosis on the basis of the clinical and histological similarities between this disorder and actinic keratosis. Moreover, it is a safe, well tolerated technique associated with good cosmetic results and minimal side effects. However, the results of the few documented cases are contradictory. Most studies have been carried out in patients with disseminated superficial actinic porokeratosis and various photosensitizing agents have been used (δ-aminolevulinic acid, MAL, and hypericin), all with poor results. The lesions resolved in only 1 case, and improved slightly or remained unchanged in the others. In the literature, we found only 1 case of porokeratosis of Mibelli that had been successfully treated with PDT. Unlike our case, those authors used a single session of PDT with MAL and blue light in combination with daily application of 5-fluorouracil cream. While the normal PDT regimen in the treatment of most skin disorders involves more than 1 session, we were...
only able to apply a single session in the present case owing to
the appearance of side effects, and this may explain the
incomplete response obtained. However, it is also possible
that the immunomodulatory effect of PDT and the inflam-
ination already present in the lesion (visible in the clinical
and histological images) may have favored a good therapeu-
tic response with just 1 session. Ulceration is a rare adverse
event,8 and its appearance was probably due in some mea-
sure to the fact that the patient was an elderly woman and
the leg was exposed to sunlight after treatment, contrary to
express instructions.

In conclusion, we report a case of porokeratosis of Mibelli
in which treatment with PDT obtained a partial response.
Nevertheless, because the results achieved with photody-
namic therapy in the treatment of porokeratosis are highly
varied, we believe that further studies with larger series
cases are needed if we are to reach clear conclusions
regarding its utility in this setting.

References

1. Levitt J, Emer JJ, Emanuel PO. Treatment of porokeratosis of
Mibelli with combined use of photodynamic therapy and fluo-
2. Ruiz de Casas A, Moreno-Ramírez D, Camacho-Martínez F.
Porokeratosis actínica superficial diseminada. Piel. 2006;21:
193-6.

Pérez-García B, Jaén P. Terapia fotodinámica: nuevas indica-
4. Nayeemuddin FA, Wong M, Yell J, Rhodes LE. Topical photody-
namic therapy in disseminated superficial actinic porokeratosis.
5. Cavicchini S, Tournaki A. Successful treatment of disseminated
superficial actinic porokeratosis with methyl aminolevulinate-
6. Fernández-Guarino, Harto A, Pérez-García B, Martín-González M,
Urrutia S, Jaén P. Photodynamic therapy in disseminated super-
7. Boly A, de Witte PA, Roelands R. Topical treatment of
disseminated superficial actinicporokeratosis with hypercin-
photodynamic therapy: a case report. Photodiagnosis Photodyn
8. Strauss RM, Ogden S, Sheehan-Dare RA, Goulden V. Leg ulcer-
ation after aminolevulinic acid photodynamic therapy in a patient

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Fabry Disease and the Clinical Spectrum of
Angiokeratomas∗

Enfermedad de Fabry: espectro clínico de los
angioqueratomas

To the Editor:

After Gaucher disease, Fabry disease is the most common
storage disease caused by the progressive accumulation
of glycosphingolipids in multiple organs. Clinical presenta-
tion is very varied, and furthermore, the manifestations
in many of the organs affected are nonspecific.1 Diagnosis
is thus challenging and often delayed. The average
time from onset of symptoms to a diagnosis of Fabry
disease is around 10 years.2 Cutaneous involvement is
common and is one of the key signs that can lead a physi-
cian to suspect the disease. Skin manifestations include
angiokeratomas, telangiectasias, abnormal sweating, and
lymphedema. Recent studies of cutaneous involvement in
Fabry disease have shown that the clinical spectrum of
angiokeratomas is also varied.3 We performed a retrospec-
tive review of skin lesions in 5 patients (4 males and 1
female) with Fabry disease, with a particular focus on
the clinical variants of angiokeratomas. The main clinical
features are shown in Table 1. The majority of patients,
including the only woman, had classic extracutaneous man-
ifestations. The mean age at onset of angiokeratomas was
17.2 years. Patients #4 and #5 had a classic bathing trunk
appearance, and patient #5 also had less hyperkeratotic
vascular lesions on the palms of both hands. The other
3 patients had less characteristic angiokeratomas. Patient
#1 had small, isolated lesions around the mouth and the
umbilicus (Fig. 1), while patient #3 had extensive angioker-
atomas distributed almost exclusively on the left side of the
body. Finally, patient #2, who was heterozygous, had lesions
in the form of angiokeratomas on the left side of the vulva
(Fig. 2) and small isolated lesions on the anterior surface of
the trunk. Just 2 of the patients had hypohidrosis. With
the exception of patient #1, all the patients were receiving
enzyme replacement treatment, with a mean uninterrupted
therapy period of 9 years; there had been no signs of
the angiokeratomas disappearing or becoming smaller or any
improvements in the other skin manifestations.

Angiokeratoma corporis diffusus is one of the 5 known
types of angiokeratoma.4 It is highly characteristic of Fabry
disease, but can also be seen in other lysosomal storage
diseases.5,6 Angiokeratomas, which can appear in childhood
or adulthood, develop in 66% of male patients with Fabry
disease and in 36% of female patients.7 While the term
angiokeratoma corporis diffusum suggests the presence of
multiple angiokeratomas, this is not always the case. Fur-
thermore, as seen in 3 of the 5 cases we describe, the lesions

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