Indian Journal of
Dermatology, Venereology & Leprology
Journal indexed with SCI-E, PubMed, and EMBASE

Vol 74 | Issue 1 | Jan-Feb 2008

CONTENTS

EDITORIAL REPORT - 2007

IJDVL gets into the Science Citation Index Expanded!
Uday Khopkar ............................................................................................................................................................... 1

EDITORIAL

Registration and reporting of clinical trials
Uday Khopkar, Sushil Pande ....................................................................................................................................... 2

SPECIALTY INTERFACE

Preventing steroid induced osteoporosis
Jyotsna Oak ................................................................................................................................................................... 5

REVIEW ARTICLE

Molecular diagnostics in genodermatoses - simplified
Ravi N. Hiremagalore, Nagendrachary Nizamabad, Vijayaraghavan Kamasamudram ........................................... 8

ORIGINAL ARTICLES

A clinicoepidemiological study of polymorphic light eruption
Lata Sharma, A. Basnet ................................................................................................................................................ 15

A clinico-epidemiological study of PLE was done for a period of one year to include 220 cases of PLE of skin type between IV and VI. The manifestation of PLE was most common in housewives on sun exposed areas. Most of the patients of PLE presented with mild symptoms and rash around neck, lower forearms and arms which was aggravated on exposure to sunlight. PLE was more prevalent in the months of March and September and the disease was recurrent in 31.36% of cases.

Comparative study of efficacy and safety of hydroxychloroquine and chloroquine in polymorphic light eruption: A randomized, double-blind, multicentric study
Anil Pareek, Uday Khopkar, S. Sacchidanand, Nitin Chandurkar, Geeta S. Naik ................................................... 18

In a double-blind randomized, comparative multicentric study evaluating efficacy of antimalarials in polymorphic light eruption, a total of 117 patients of PLE were randomized to receive hydroxychloroquine and chloroquine tablets for a period of 2 months (initial twice daily dose was reduced to once daily after 1 month). A significant reduction in severity scores for burning, itching, and erythema was observed in patients treated with hydroxychloroquine as compared to chloroquine. Hydroxychloroquine was found to be a safe antimalarial in the dosage studied with lesser risk of ocular toxicity.
Many faces of cutaneous leishmaniasis
Arfan Ul Bari, Simeen Ber Rahman
Symptomatic cutaneous leishmaniasis is diverse in its presentation and outcome in a tropical country like Pakistan where the disease is endemic. The study describes the clinical profile and atypical presentations in 41 cases among 718 patients of cutaneous leishmaniasis. Extremity was the most common site of involvement and lupoid cutaneous leishmaniasis was the most common atypical form observed. Authors suggest that clustering of atypical cases in a geographically restricted region could possibly be due to emergence of a new parasite strain.

Forehead plaque: A cutaneous marker of CNS involvement in tuberous sclerosis
G. Raghu Rama Rao, P. V. Krishna Rao, K. V. T. Gopal, Y. Hari Kishan Kumar, B. V. Ramachandra
In a retrospective study of 15 patients of tuberous sclerosis, eight patients had central nervous system involvement. Among these 8 cases, 7 cases had forehead plaque. This small study suggests that presence of forehead plaque is significantly associated with CNS involvement.

BRIEF REPORTS

Ligand-binding prediction for ErbB2, a key molecule in the pathogenesis of leprosy
Viroj Wiwanitkit

SCORTEN: Does it need modification?
Col. S. S. Vaishampayan, Col. A. L. Das, Col. R. Verma

CASE REPORTS

Universal acquired melanosis (Carbon baby)
P. K. Kaviarasan, P. V. S. Prasad, J. M. Joe, N. Nandana, P. Viswanathan

Adult onset, hypopigmented solitary mastocytoma:
Report of two cases
D. Pandhi, A. Singal, S. Aggarwal
Incidental finding of skin deposits of corticosteroids without associated granulomatous inflammation: Report of three cases
Rajiv Joshi ............................................................... 44

Erythromelanosis follicularis faciei et colli: Relationship with keratosis pilaris
M. Augustine, E. Jayaseelan ..................................... 47

Naxos disease: A rare occurrence of cardiomyopathy with woolly hair and palmoplantar keratoderma

Granular parakeratosis presenting with facial keratotic papules
R. Joshi, A. Taneja .................................................... 53

Adult cutaneous myofibroma
V. Patel, V. Kharkar, U. Khopkar .................................. 56

LETTERS TO THE EDITOR

Extragenital lichen sclerosus of childhood presenting as erythematous patches
N. G. Stavrianeas, A. C. Katoulis, A. I. Kanelleas, E. Bozi, E. Toumbis-Ioannou .......... 59

Leukocytoclastic vasculitis during pegylated interferon and ribavirin treatment of hepatitis C virus infection
Esra Adisen, Murat Dizbay, Kenan Hize, Nilsel İlter .................................................. 60
<table>
<thead>
<tr>
<th>Title</th>
<th>Authors</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poland’s syndrome</td>
<td>Saurabh Agarwal, Ajay Arya</td>
<td>62</td>
</tr>
<tr>
<td>Hereditary leiomyomatosis with renal cell carcinoma</td>
<td>Sachin S. Soni, Swarnalata Gowrishankar, Gopal Kishan Adikey, Anuradha S. Raman</td>
<td>63</td>
</tr>
<tr>
<td>Infantile onset of Cockayne syndrome in two siblings</td>
<td>Prerna Batra, Abhijeet Saha, Ashok Kumar</td>
<td>65</td>
</tr>
<tr>
<td>Multiple xanthogranulomas in an adult</td>
<td>Surajit Nayak, Basanti Acharjya, Basanti Devi, Manoj Kumar Patra</td>
<td>67</td>
</tr>
<tr>
<td>Bullous pyoderma gangrenosum associated with ulcerative colitis</td>
<td>Naik Chandra Lal, Singh Gurcharan, Kumar Lekshman, Lokanatha K</td>
<td>68</td>
</tr>
<tr>
<td>Sporotrichoid pattern of malignant melanoma</td>
<td>Ranjan C. Rawal, Kanu Mangla</td>
<td>70</td>
</tr>
<tr>
<td>Acitretin for Papillon-Lefèvre syndrome in a five-year-old girl</td>
<td>Didem Didar Balci, Gamze Serarslan, Ozlem Sangun, Seydo Homan</td>
<td>71</td>
</tr>
<tr>
<td>Bilateral Becker’s nevi</td>
<td>Ramesh Bansal, Rajeev Sen</td>
<td>73</td>
</tr>
<tr>
<td>Madarosis: A dermatological marker</td>
<td>Silonie Sachdeva, Pawan Prasher</td>
<td>74</td>
</tr>
</tbody>
</table>
### FOCUS

**Botulinum toxin**  
Preeti Savardekar

---

### E-IJDVL

#### Net Studies

**A study of oxidative stress in paucibacillary and multibacillary leprosy**  
P. Jyothi, Najeeba Riyaz, G. Nandakumar, M. P. Binitha

---

**Clinical study of cutaneous drug eruptions in 200 patients**  
M. Patel Raksha, Y. S. Marfatia

---

#### Net case

**Porokeratosis confined to the genital area: A report of three cases**  
Sujata Sengupta, Jayanta Kumar Das, Asok Gangopadhyay

---

#### Net Letters

**Camisa disease: A rare variant of Vohwinkel’s syndrome**  
T. S. Rajashekar, Gurcharan Singh, Chandra Naik, L. Rajendra Okade

---

**Cross reaction between two azoles used for different indications**  
Arika Bansal, Rashmi Kumari, M. Ramam

---

#### Net Quiz

**Asymptomatic erythematous plaque on eyelid**  
Neeraj Srivastava, Lakhan Singh Solanki, Sanjay Singh

---

#### Quiz

**A bluish nodule on the arm**  
Ragunatha S., Arun C. Inamadar, Vamseedhar Annam, B. R. Yelikar

---

### REFEREE INDEX-2007

### INSTRUCTIONS FOR AUTHORS

The copies of the journal to members of the association are sent by ordinary post. The editorial board, association or publisher will not be responsible for non-receipt of copies. If any of the members wish to receive the copies by registered post or courier, kindly contact the journal’s/publisher’s office. If a copy returns due to incomplete, incorrect or changed address of a member on two consecutive occasions, the names of such members will be deleted from the mailing list of the journal. Providing complete, correct and up-to-date address is the responsibility of the members. Copies are sent to subscribers and members directly from the publisher’s address; it is illegal to acquire copies from any other source. If a copy is received for personal use as a member of the association/society, one cannot resale or give-away the copy for commercial or library use.
Porokeratosis confined to the genital area: A report of three cases

Sujata Sengupta, Jayanta Kumar Das, Asok Gangopadhyay
Department of Dermatology, R.K.M. Seva Pratisthan and V.I.M.S, Kolkata, India

Address for correspondence: Dr. Sujata Sengupta, UV 24/3C, Udayan, 1050/1, Survey Park, Kolkata - 700 075, West Bengal, India.
E-mail: senguptasujata@yahoo.co.in

ABSTRACT

Genital involvement in porokeratosis (PK) is a rare occurrence even in disseminated forms. We encountered three patients who had porokeratosis affecting only the genital area. Two of them were male with involvement of the penis and scrotum and only the scrotum respectively. The lady with vulvar involvement is a hitherto unreported instance of porokeratosis confined to female genitalia. None of the cases were very easy to diagnose clinically but biopsies proved confirmatory. The male patients were advised light electrocautery under local anesthesia while the female patient underwent surgical excision. No malignant change has been reported in them till date.

Key Words: Female genitalia, Genital porokeratosis, Porokeratosis

Porokeratosis (PK) is a clonal disorder of keratinization showing one or multiple atrophic patches surrounded by a distinct ridge-like border. The common clinical variants include classical plaque-type porokeratosis of Mibelli (PM), disseminated superficial porokeratosis, linear porokeratosis, porokeratosis palmaris et plantaris disseminate and punctate porokeratosis.[1] Genital porokeratosis (GP), though uncommon, can occur as a part of a more generalized involvement.[2] But PK localized to the genital area is a rare entity. We report such an occurrence in one female patient and two male patients.

CASE REPORTS

Case 1
A 36-year-old housewife from a rural socioeconomic background presented with a dry, itchy vulvar lesion for the last 8 months. There was no history of sexual promiscuity or local irradiation and her family history was not significant. Topical steroids, antifungal and antibiotic creams had yielded no results. A hyperkeratotic verrucous plaque, 2 × 1.5 cm, was seen involving the vestibule, fourchette and adjacent perineal skin [Figure 1]. No similar skin lesion was present anywhere else in her body and systemic examination was normal. Histology from the edge of the skin lesion showed a parakeratotic column (cornoid lamella) in the epidermal invagination and underlying hypogranulosis [Figure 2]. A mild perivascular infiltrate was seen in the dermis. She was diagnosed to have vulvar PK. She was advised surgical excision.

Case 2
A 35-year-old businessman presented with slowly spreading multiple asymptomatic brownish lesions on the scrotum and penis for the last 8 months. There was no history of extramarital sexual exposure, drug intake; and his family history was noncontributory. Topical and systemic steroids had produced no results. Several well-defined hyperpigmented annular plaques of varying sizes were seen on the penile shaft and scrotum [Figure 3]; each one had a mildly scaly atrophic center and a raised border [Figure 4]. The rest of the skin and systemic examination was normal. We initially considered the genital lesions to be annular lichen planus (LP), but a biopsy was advised. Histopathology was typical of PK with the cornoid lamella and epidermal invagination.

Case 3
A 34-year-old man reported with an asymptomatic plaque on the scrotal skin for the last 3 months. It had started as a small papule, which expanded slowly to its present size. His

How to cite this article: Sujata Sengupta, Jayanta Kumar Das, Asok Gangopadhyay. Porokeratosis confined to the genital area: A report of three cases. Indian J Dermatol Venereol Leprol 2008;74:80.
family and sexual history was not significant. He had a 1.5 × 1 cm depigmented annular keratotic plaque on the scrotal skin that was surrounded by a raised border [Figure 5]. On close inspection, the border was found to be traversed by a groove. Skin biopsy was consistent with PK. The lesion healed, with a thin scar, after electrodesiccation under local anesthesia.

None of the three patients had inguinal adenopathy or any evidence of sexually transmitted disease (STD). Routine hematological and biochemical tests were normal and VDRL and ELISA for HIV were negative. Till date, malignant change has not been seen.

**DISCUSSION**

PK confined to the genital area is rarely seen. We came across
about 20 such cases in English literature. Surprisingly, all the cases were males. PK is two to three times more common in males than in females, but GP in females seems even rarer. Robinson et al. gave the first report of vulvar PK in a 39-year-old lady who had disfiguring lesions in the perineal area, medial thigh and sole. But our report of the female patient is probably the first report of PK confined to female genitalia.

PK localized to the male genitalia has been reported most commonly in the scrotum, followed by penis, buttock, natal cleft, groins and adjacent thighs. Porter et al. came across a case involving the external urethral meatus that was treated with topical 5-fluorouracil. In our cases PK was localized to the penis and/or scrotum and involvement of skin adjacent to genitalia was not seen. Though the inheritance of PK is known to be autosomal dominant, none of our cases had a positive family history. Similarly, family history was noncontributory in all the 10 cases studied by Chen and his colleagues. In contrast to their study, none of our patients had diabetes or sexually transmitted diseases (STDs). Malignant transformation into squamous or basal cell carcinoma has been seen in almost all forms of PK. We have earlier reported multicentric squamous cell carcinoma (SCC) of the inguinal lesions of disseminated PK. But that patient did not have genital lesions. In fact, malignant change has not been found in GP till date.

Clinically, none of the cases were very easy to diagnose. We thought of condyloma acuminata in Case 1; but there was no sexual promiscuity and the response to imiquimod was unsatisfactory. This uncommon verrucous form of PK has been reported to occur over scrotum and buttocks. In Case 2, the annular plaques had raised borders but no typical ridge was seen. We considered lichen planus but extragenital or oral lesions were not seen. Annular syphilide was another possibility but VDRL was negative. A distinct keratotic ridge helped to diagnose Case 3 even though the center was depigmented.

The treatment options of GP are cryotherapy (liquid N\_2), surgery, CO\_2 laser, topical 5% 5-fluorouracil and imiquimod cream. We found that all our patients had been previously treated for GP with either antifungals or topical and systemic steroids. This highlights the possibility that PK confined to the genital area is an under-diagnosed entity and can be easily confused with STDs and other nonvenereal diseases affecting genitalia. A thorough clinical evaluation is mandatory and skin biopsy may be diagnostic in such cases. In addition, keeping in mind the potential for malignancy, all diagnosed cases should receive regular follow-up.

REFERENCES