

## Porokeratosis of Mibelli

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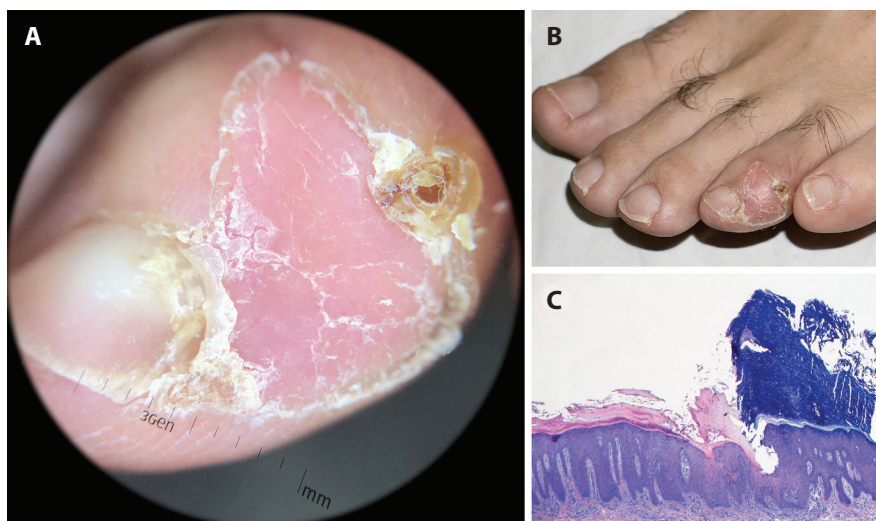
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### Case Presentation

A 52-year-old man with no past medical history presented with an asymptomatic annular atrophic patch on the distal portion of the fourth toe of 2 years' duration (Figure 1B). The lesion began as a small keratotic papule that gradually enlarged centrifugally. He had received multiple treatments including cryotherapy, topical corticosteroids, antifungals,

and antibiotics without improvement. Dermoscopic examination revealed a scaly atrophic erythematous central area with a sharply demarcated peripheral hyperkeratotic structure (Figure 1A). A skin biopsy of the edge of the lesion revealed a cornoid lamella with a column of parakeratotic cells extending from an invagination of the epidermis with absence of granular layer (Figure 1C). The clinicopathologic correlation was consistent with porokeratosis of Mibelli.



**Figure 1.** (A) Polarized dermoscopy (DermLite II PROHR; magnification  $\times 10$ ) reveals a scaly atrophic erythematous central area, with a sharply demarcated peripheral hyperkeratotic structure (cornoid lamella). (B) Unilateral annular patch on the distal portion of the fourth toe of the left foot. (C) Punch biopsy of the edge of the lesion reveals a cornoid lamella with a column of parakeratotic cells extending from an invagination of the epidermis with absence of granular layer; H&E, magnification  $\times 40$ .

## Teaching Point

Porokeratosis can be mistaken with cutaneous squamous cell carcinoma in situ [1], tinea corporis, and circumscribed planar hypokeratosis, among other annular lesions. Dermoscopy is a useful tool that improves diagnostic accuracy and allows visualization of the cornoid lamella [2].

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