A 34-year-old female presented with a one-year history of an intensely pruritic rash on her buttocks. She reported that the rash had increased in size and intensity over the past year. The patient unsuccessfully treated the area with an unknown topical medicament that she received from her primary care doctor. She denied any other family member having a similar rash. A review of symptoms was negative for a preceding illness or constitutional symptoms.

Physical examination revealed a healthy appearing female with well-demarcated scaly pink plaques located in the gluteal cleft. The lesions appeared to spare the central crease and were tender. The remainder of the exam was essentially normal. A presumptive diagnosis was made of psoriasis, and the patient was given Elocon cream (Mometasone Furoate, Merck) to apply at night. Upon her return to the clinic 10 days later, the lesions had begun to have verrucous changes centrally and continued to spread across her bilateral buttocks. The current treatment was discontinued and the patient was started on Aldara (imiquimod 5%, Medicis) for a presumptive diagnosis of condyloma acuminatum. The following visit revealed no improvement, and a 4mm punch biopsy was taken from a verrucous plaque on the right gluteal cleft.

Microscopic examination revealed cortical columns of parakeratosis present in discrete foci with a diminished granular zone and dyskeratotic keratinocytes. Epidermal hyperplasia was also noted. Testing for strains of human papillomavirus (HPV) were all negative. The patient was instructed to continue the use of Aldara and periodic cryotherapy was performed to the most hyperkeratotic areas. The patient returned, having obtained resolution of 90 percent of lesions.

“All forms of porokeratosis have been reported to have malignant degeneration with a risk of 7.5 percent.”

Verrucous porokeratosis: A 34-year-old female presented with a one-year history of an intensely pruritic rash on her buttocks. Physical examination revealed well-demarcated scaly pink plaques located in the gluteal cleft.
within months, and she had only a few papules remaining. We continue to monitor and treat the patient.

**DISCUSSION**

Verrucous porokeratosis (VP), otherwise known as porokeratosis ptychotropica, was first described in 1995 by Lucker et al.1 Being clinically and histologically distinct from the numerous other variants of porokeratosis, VP represents a unique and rare variant in the clinical spectrum. Usually described as a pruritic keratotic plaque, it presents as a confluent perianal lesion that is symmetric on both sides of the buttocks with possible satellite lesions.

The hallmark of porokeratosis is the presence of cornoid lamellae on histological exam. VP is no different, except it is unique in that multiple foci of cornoid lamellae are present rather than two discrete foci.2 The presence of amyloid deposition in porokeratosis is uncommon, but most cases of VP report having dermal amyloid deposition. This variation could be due to friction, which has been implicated as a cause of amyloid deposition in many other itching lesions.3

Several theories exist as to the origin of porokeratosis, but none as to the exact origin of VP. A viral infection has been proposed for several variants of porokeratosis4 and may best describe this entity due to the perianal location, verrucous nature of the lesion, and the fact that cornoid lamellae have been seen on verruca. Interestingly, in our case, human papillomavirus typing did not reveal any strains of human papillomavirus, negating this theory. Hivnor, et al.5 reported similarities in gene expression between porokeratosis and psoriasis, indicating that perhaps porokeratosis is an inflammatory disorder. This is an interesting notion, as the lesion in this case clinically appeared to resemble inverse plaque psoriasis and was initially diagnosed as psoriasis.

All forms of porokeratosis have been reported to have malignant degeneration, with a risk of 7.5 percent.6 Risk is more common in large lesions, those of long-standing duration, and linear subtype. The formations of squamous cell carcinoma (SCC) and basal cell carcinoma (BCC) are those most commonly reported. Therefore, we treated our patient with a combination of Aldara and cryotherapy. Although we have been successful with this regime, the only beneficial treatment reported in the literature thus far for VP has been dermabrasion.7 Other therapeutic options include 5-flourouracil, topical and intraleisonal steroids, oral retinoids, and CO2 laser.