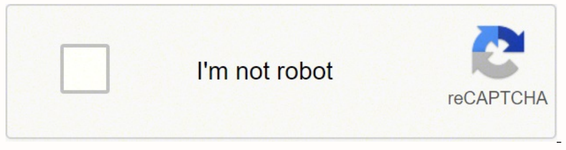
Acquired perforating dermatosis treatment



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Acquired perforating dermatosis causes. Perforating dermatosis treatment.

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Recognition The authors and publishers of Medscape Reference acknowledge the contribution of the previous author, Kristiana Gray, MD, to the development and drafting of this article. 1.GarcÃ-a-Malinis AJ, Del Valle SE, SÃ¡nchez-Salas MP, Del Prado E, Coscojuela C, Gilaberte Y. Perforated dermatosis rating: clinicalopathological study of 31 cases,and treatment. J Eur Acad Dermatol Venereol. 2017;31:1757–63.Article Google Scholar 2.Reid J, Almond L, Matthewman N, Stringer H, Francis N, Al AM. A case of collagenous reactive perforant acquired. Australas J Dermatol. 2018;59:e75–6. Article Google Scholar 3.Karpouzis A, Giatromanolaki A, Sivridis E, Kouskoukis C. Perforating reactive collagen acquisite: current state. J Dermatol. 2010;37:585–92. Article Google Scholar 4. Hoque SR, Ameen M, Holden CA. collagenous reactive forata acquired: four patients with a giant variant treated with allopurinol. Br J Dermatol. 2006; 154:759–62.CAS Article Google Scholar 5.Tsai TF, Yeh TY. 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Dermatol Ther. 2009;22:85–9.CAS Article Google Scholar Page 2a–c Physical examination that reveals ulcers in the shape of a shallow cup in the ends and a linear distribution of skin lesions. d Dermoscope revealed a rounded ulcer covered with yellow crusts at the fifth week Perforating reactive dermatosis is a rare chronic skin disease defined by the transepidermal elimination of collagen and/or elastin. In the form acquired in adults, it is often associated with diseases such as diabetes and chronic kidney failure. Systematic revisions of treatment options for this disease are not available. The goal of this systematic review is to sum up all the processing options reported for the acquired reactive damper (ARPD). This is a systematic review based on a MEDLINE research of articles in English and German from 1990 to 2016. Most of the medical literature on the treatment of ARPD is limited to individual case reports and small patient series. Various therapies that have been proven include antihistamines, topical keratolytics, corticosteroids, tretinoin, oral drugs such as allopurinol or antibiotics, and phototherapy or photochemotherapy. Although there are no specific criteria for selecting test-based treatment optionsARPD, the first priority in managing these conditions should be the treatment of a basic disease ifNone of the methods described were approved for first-line therapy. It is recommended to choose a combination of medications that reduce itching and help in solving skin lesions at once. The acquired perforating dermatosis (APD) is an uncommon disease characterized by injuries that expose the transepidermal elimination of collagen or elastic fibers. APD affects adults and is associated with systemic diseases, mainly diabetes mellitus and kidney failure. We present 8 cases of APD. Seven patients had mellitus concurrent diabetes with or without chronic kidney failure, and 1 had alcoholic cirrhosis. In patients with chronic kidney failure, the beginning of APD coincided with a transitory worsening of kidney function. The average increase in creatinine concentrations over the baseline was 1.14mg/dL The deterioration of renal function acute may be involved in APD. Further studies are required to investigate this association. Acquired Perforated Dermatosis Transhepidermal Elimination La dermatosis perforante adquirida (DPA) es una enfermedad infrecuente caracterizada por la aparición de lesiones que presentan Eliminación transepidérmica de colágeno o fibers elásticas. Afecta a razze y se asocia a enfermedades sistémicas, mainly diabetes mellitus and insuficiencia renal. 8 casos Present de DPA, 7 with diabetes mellitus and insuficiencia renal crónica (IRC) y uno con cirrosis alcohólica. Los pacientes con IRC tuvieron un empeoramiento transitorio de la misma coincidecidiendo con la aparición de la DPA. Creatine if elevó de media 1,14mg/dl. El deterioro agudo de la función renal podría estar implicado en la DPA. Se necesitan más estudios para confirmar esta relación. Dermatosis perforante adquiridaEliminación transepidérmicaInsuficiencia renal crónica Introduction Perforating dermatosis are a heterogeneous group of diseases characterized by the transepidermal elimination of one or more skin components. Four types are traditionally recognized: Elastosi perforated serpiginosum, perforating follicles, Kyrle disease, and reactive perforating collagen (RPC.) Two variants of PRC have been described: a rare hereditary form that presents in childhood and a more common form that appears in adult life and affects mainly diabetic patients with chronic kidney failure (CRF).1 Over the years, there has been a certain degree of confusion regarding terminology. Currently, most authors use the term collagenous reactive perforant for the hereditary form, while the term acquired perforating dermatosis (APD,) proposed by Rapini et al. is preferred for adult form and for any perforating disease that is clinically and histologically similar to primary disease, but which is associated with a systemic disease. 1APD is a rare disease. Most descriptions are in shapereports of isolated cases; there are a number of cases. 2-4 We present you a series of 8 cases. Descriptions of the cause We present 8 cases of APD in men and 5 women with an average age of 73 years (Table 1). The time between onset of symptoms and diagnosis ranged from 2 weeks to 4 months, with an average of 5.5 weeks.Clinically, patients had multiple umbilical papules, strongly itchy and with a well-adherent central keratotic plug (Figures 1 and 2). The most common sites were the back and lower limbs. A histopathological study, conducted on all patients with haematoxylin-eosin, Masson trichromica and Verhoeff, revealed epidermal hyperplasia with cup-shaped central depression covered by keratin and cell remnants, as well as transpidermal elimination of vertical collagen fibres (Fig. 3, A and B). Elimination of elastic fibres was not observed in any of the patients. All patients met the diagnostic criteria proposed by Faver: umbilical papules or nodules with an adherent keratotic center, histopathological identification of basophilic collagen elimination, and skin lesions after age 18.5 Diabetes mellitus (DM), with or without CRF, was the most common type of disease. The most common association and was present in 7 cases. Three patients had liver disease (fatty liver, alcoholic cirrhosis and chronic liver disease caused by the hepatitis C virus).All patients with DM and/or CRF had a deterioration of kidney function with the onset of skin lesions. The increase in creatinine level was 0.36-1.90 mg/dL, with a mean increase of 1.14 mg/dL from baseline, and levels returned to baseline in follow-up laboratory tests after 1-2 months. Most of our cases have been treated with topical corticosteroids and antihistamines; 1 patient received narrowband UV-B and another received topical antibiotics and copper sulphate poles. Lesions resolved within 1-4 months (mean, 2.6 months), leaving residual hyperpigmented scars. The 1-year follow-up did not reveal any new lesions.DiscussionAcquired perforating dermatosis, introduced in 1989 by Rapini et al.,6 refers to perforating dermatoses that appear in adults and are associated with systemic diseases (mainly DM and CRF). Previous publications by Rapini et al. used other terms to refer to this disease (Kyrle-like lesions, haemodialysis perforating folliculitis, Kyrle's disease in patients with CRF, uremic follicular hyperkeratosis, elastic perforating pseudoxanthoma associated with CRF and haemodialysis, elastasis for serpiginosum, and reactive perforating collagenosis of DM and CRF7"9), aggravating the confusion that has so far surrounded this disease. APD presents as a skin rash of umbilicalized papules with a central keratotic cap and is associated with diffuse pruritus. The most common sites are the trunk and limbs, usually in areas accessible to scratch and sometimes show a linear, as manifestations of the Koebner phenomenon.Histopathology reveals the results of any of the 4 classic piercing diseases, and more 1 pattern can be seen in a single patient.2,6 APD has been reported in association with numerous systemic diseases (Table 2). A typical case would be a patient with DM and CRF of diabetic origin. DM is generally long-lasting and microangiopathic and macroangiopathic complications may occur.6,10 Other causes of CRF have also been reported, such as infection with human immunodeficiency virus,6 immunoglobulin A nephropathy, glomerulonephritis, and heroin abuse.10 L APD can develop during various liver diseases without DM and/or CR. F, as happened in case 7 of our series. These liver diseases include viral hepatitis (hepatitis A, B or C virus), fatty liver,2 cirrhosis, hepatocellular carcinoma and liver metastases.Our 7 patients with DM and/or CRF had a deterioration in renal function concomitantly with the Onset of skin lesions. In a literature review, we did not find any evidence to suggest that creatinine levels may play a role in the development of APD or uremic itching. The temporal coincidence of increased creatinine levels and the onset of APD lesions observed in our patients suggests that there may be a relationship between acute renal impairment and APD in patients with CRF and/or DM. However, due to the small number of patients in our group, we cannot establish a causal relationship between acute renal impairment and the onset of APD. Studies with a larger number of patients would be needed to confirm this combination.The pathogenesis of APD is not fully understood. The most widely accepted hypothesis involves itching as the main trigger, as is present in all cases. The scratch produces a microtrauma that leads to changes in the collagen fibers of the papillary dermis, facilitating transpidermal elimination as a final step.2,6 Numerous skin or systemic diseases that cause itching and scratches may thus lead to the onset of APD in patients with underlying metabolic abnormalities.11 Some literature has linked the onset of APD to dialysis,10 but it has subsequently been shown that APD can occur both before and after dialysis. In addition, APD may occur in patients on haemodialysis, on peritoneal dialysis, or even in patients without dialysis.7,10 Although improvements in APD lesions have been reported after kidney transplantation, some patients have developed APD lesions after transplantation, as occurred in cases 1 and 5 of our series. 2 The most commonly used are emollients, keratolytics, topical retinoids, topical, oral or intradermal corticosteroids, phototherapy (broadband and narrowband UV-B), photochemotherapy (psoralen UV-A),12e allopurinol.1 Other options, including oral, doxycycline, rifampicin, amitriptyline, surgical deflection, electrical stimulation of the nerve, nerve, The APD develops in patients with widespread itching and systemic diseases, the most common association with DM and CRF. We present a series of 8 cases of APD, 7 with DM, of which 5 also CRF, and a single patient with liver cirrhosis. In all patients with DM and/or CRF a deterioration of kidney function has been observed, which coincided with the occurrence of APD. In patients with DM and/or CRF of diabetic origin, acute deterioration of kidney function can be implied in the onset of APD. Further studies are needed to confirm this report. Ethic DivulgationProtects of human and animal subjectsThe authors declare that they have not carried out experiments on humans or animals for this investigation. Data confidentiality Authors declare that they have complied with the norms of their hospital regarding the publication of the patient's information and have obtained for all patients the informed consent written to voluntary participation. Right to privacy and informed consent The authors declare that not in this article the personal data of patients are disclosed. Interest conflicts Authors declare that they have no conflicts of interest. Please cite this article as: GonzÃ¡lez-Lara L, GÃ3mez-Bernal S, VÃ¡zquez-LÃ3pez F, Vivanco-Allende B. Dermatosi perforante acquired: presentation of 8 cases. Actas Dermosifiliogr. 2014;105:e39»e43. Copyright © 2013. Elsevier EspaÃ±a, S.L. and AEDV AEDV