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Figure 1. Immunohistochemical analysis of the dermis showing a
mixture of CD31+ endothelial cells and CD68+ macrophages
(Figures 1 and 2). These results indicate that the dermis contains a
heterogeneous population of immune cells, including a significant
count of CD68+ macrophages.

**Correspondence**

and tropé (a turning), and has been used previously to distinguish the ichthyosiform naevus in the CHILD syndrome, which has a pronounced affinity for the body folds, from all other naevi or naevoid conditions which are not psychotropic.8

A 34-year-old man presented with a pruritic dermatosis confined to the natal cleft. The disease had been present for 9 years, and had gradually become more extensive. Previous treatment had consisted of topical steroids, which relieved the pruritus but did not otherwise influence the lesions. There was no family history of similar skin lesions, or of porokeratosis. On examination, there were multiple erythematous, keratotic papules, which were discrete at the margins of the affected area, but coalesced towards the centre to form a plaque (Fig. 1). The rest of the skin was normal.

Histology of a skin biopsy showed orthohyperkeratosis, acanthosis, and papillomatosis of the epidermis, and typical cornoid lamellae. Beneath the cornoid lamellae, the granular cell layer was absent, and there were numerous dyskeratotic cells. There was a non-specific mononuclear cell infiltrate in the upper dermis (Fig. 2). Focally these lesions were found to extend into the hair follicles.

He was treated with topical all-trans-retinoic acid 0-05%, which was applied thinly and evenly once daily. Despite some slight improvement after 1 month, the treatment was eventually discontinued because of unacceptable irritation of the skin.

The characteristic histological feature of all porokeratotic variants is the cornoid lamella. Clinically, most types of porokeratosis consist of lesions characterized by central atrophy and a hyperkeratotic margin. Hyperkeratotic lesions with a centrally keratotic or even verrucous surface may be found in linear prokeratosis and porokeratosis of Mibelli.9 Porokeratotic lesions usually remain asymptomatic, although intense pruritus has been reported to occur in disseminated superficial porokeratosis.10

The morphology and localization of the lesions in our patient differ from the known clinical variants of porokeratosis. and we consider these features may represent a distinctive type of porokeratosis involving the body folds. We propose the designation ‘porokeratosis psychotropica’ to distinguish this porokeratotic variant.

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References

More than 1000 J/cm2 of UVA for PUVA treatment of psoriasis

Sir, The guidelines for management of patients with psoriasis produced by the Workshop of the Research Unit of the Royal College of Physicians of London, the Department of Dermatology, University of Glasgow and the British Association of Dermatologists2 is a useful document. In the section on PUVA therapy it is stated that the total lifetime exposure to UVA should (if possible) be a maximum of 1000 J/cm2. We were aware that we had many patients who had exceeded this limit and therefore felt it an important subject for audit.

We have identified 37 patients with psoriasis who have received over 1000 J/cm2 of UVA since PUVA was started in Devon in 1980 (Table 1). The population served is about 1.1 million, and the total number of psoriasis patients treated with PUVA to date has been approximately 300.

Our policy is to use a clearing regimen of PUVA, and then stop therapy, or sometimes to continue for 2–3 months before stopping. Most patients therefore have repeated clearing courses. The majority of high-dose patients are those who relapse promptly if PUVA is stopped, so many are on virtually continuous therapy. All patients in this group have severe psoriasis, and many have had other systemic treatments for their psoriasis (Table 2).

The main reason for continuing PUVA has been patient preference, although we periodically review all psoriasis patients on systemic treatment, and discuss alternative therapy with them. Squamous cell carcinoma has occurred in seven patients, to date, in this group of 37 high-dose UVA patients (Table 1). Most patients who receive PUVA in our area have failed to clear with dithranol and UVB or, having cleared, flared too quickly to make it a practical treatment (this study presents our findings prior to the introduction of calcipotriol; Dovonex®). All systemic agents for the treatment of psoriasis have side-effects, and it is often considered that