

[PICTURES IN CLINICAL MEDICINE]

Primary Biliary Cholangitis-associated Palmar Keratosis

Jun Usami

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Picture 1.



Picture 2.

A 66-year-old woman presented with a 1-month history of palmar keratosis. She had a history of dyslipidemia, and had been taking atorvastatin. Laboratory tests showed a normal LDL cholesterol level. A physical examination showed keratosis on the palms of both hands (Picture 1). Treatment with steroid ointment had no effect. Subsequently, an increased alkaline phosphatase (ALP) level was detected (425 IU/L; reference range, 115-359). Primary biliary cholangitis (PBC), which is a chronic cholestatic liver disease, was considered as a possible cause of the skin lesions (1). Her anti-mitochondrial antibody (AMA) titer was analyzed and confirmed to be 80 times (reference range, 0-20). Although a liver biopsy was not performed, she was confidently diagnosed with PBC. These findings were consistent with palmar keratosis of PBC, and treatment with ursodeoxycholic acid was initiated (2). A little over half a year later, an improvement of the lesions was observed, which was consistent with the improvement of her laboratory data (Picture 2). Laboratory tests showed an ALP level of 340 IU/L at that time. Diseases that can cause palmar keratosis are divided into hereditary and acquired conditions. Hereditary diseases include ichthyosis, Nagashima-type palmoplantar keratosis,

Darier's disease, and other conditions, which develop from infancy to the late teens and which are associated with a family history. Acquired diseases can be divided into inflammatory (psoriasis, pityriasis rosea, etc.) and non-inflammatory (corn, callus, etc.) conditions; however, the clinical features of the present case clearly differed from these conditions. Pruritus is common in PBC, but there are few case reports of palmar keratosis in PBC patients.

The author states that he has no Conflict of Interest (COI).

References

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General Medicine, Aichi Medical University, Japan

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Correspondence to Dr. Jun Usami, jusami176@hotmail.com

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