Keratosis circumscripta

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Dear Sir,

In 1964 [1] and 1966 [2], Shrank described 'keratosis circumscripta' as a separate entity in Nigeria. Soyinka and Laja [3] suggest that it is a variant of psoriasis. Between 1965 and 1974 we saw a number of patients who fitted Shrank's description in Kenya, East Africa. About 10 cases were studied and observed in systematic fashion, including biopsy and prolonged follow-up, as we planned to confirm Shrank's observations.

Only the localisation and sharp margins may have somewhat resembled psoriasis. Otherwise, the aspect, notably the type of hyperkeratosis, was totally different. There were deep furrows resembling lichenification or even some types of congenital ichthyosis, but no profuse silvery white scales with the wax candle phenomenon. In the histological picture, there were hardly any dermal abnormalities, notably in the papillae, or Munro's abscesses. The age distribution showed, as suggested by Shrank, a disease of children and adolescents. We could add a prolonged follow-up to Shrank's observations: The patches were remarkably stable over many months or years, they hardly responded to cortico-steroids, as suggested by Soyinka and Laja [3], and we never saw a transition into classical psoriasis.

We reported in 1967 [4] that psoriasis was by no means rare in tropical Africa and we confirmed this repeatedly [5, 6]. However, like Shrank, we hardly 'considered psoriasis in our deliberations' [3] in our cases of 'keratosis circumscripta'; there was hardly any resemblance.

We conclude that Shrank [1, 2] and Soyinka and Laja [3] have described different groups of patients and that 'keratosis circumscripta' may be found elsewhere in Africa.

However, we agree with Soyinka and Laja [3] that we found keratosis circumscripta in several tribes belonging to widely different linguistic groups and that the predominance of Yoruba's in Ibadan [1, 2] might simply reflect the composition of the local population.

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There is no doubt in our mind that there would be a lot of cases in Africa that might fit into Schrank's original description of the lesions he noticed in Nigerian patients in 1963 and which he consequently called 'keratosis circumscripta'. Neither do we dispute the fact that psoriasis is by any means rare in Africa. However, anomalous and atypical forms of psoriasis do occur in Africa as much as anywhere else, and the 'keratosis circumscripta' as originally described by Schrank would fit into this category of atypical psoriasis as we earlier on maintained.

We have not described the 'same group' of patients as Schrank. What we said was that the dermatoses we observed amongst our patients, were similar to those observed by Schrank. Our own observations of the dermatoses fitted very well into Schrank's original description. The figure 1 on page 408 of his original paper, when compared very closely with figures 2a and b (page 344) of our recent paper shows striking similarities. Even the 'bands' that Schrank described as running across the lesions were well demonstrated in our patients as shown in figure 1 of our paper. Schrank did not mention 'deep furrows' resembling 'lichenification' in his original work and neither did we observe such 'things'. What Verhagen meant by 'type of hyperkeratosis' is not clear to us.

All slides, except four missing ones from the skin biopsies done by Schrank during his stay at UCH Ibadan were thoroughly reviewed by us and we could not find any relationship between these slides and what Schrank reported as 'keratosis circumscripta'. On the other hand, the histopathological reports on the four missing slides as contained in the logbook reported 'destruction of basal layer with lymphocytic infiltrations, elongation of the rete pegs, pointed rete ridges, occasional intracellular oedema' – all of which are also characteristic of psoriasis. We were able to prove to a logical conclusion that these reports belong to the 4 patients that Schrank reported. In addition, in the serial sectioning of our cases, we had similar findings as Schrank did and we were also able to observe occasional Munro abscess.

Verhagen reported that there were 'hardly any dermal abnormalities, notably in the papillae' – but what these slight abnormalities he observed were, he did not say.

Finally, what Verhagen seems to be saying in his comment was that we have described a dermatosis totally different to Schrank's original observations – but this he has by no means supported or proved.

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