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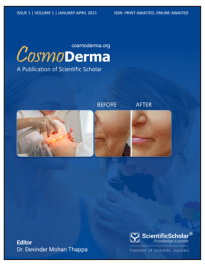

Visual Treats in Dermatology

Mal de Meleda

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A 23-year-old male presented with a history of reddish raised scaly plaques involving bilateral palms and soles from the early childhood. He gave a history of painful fissuring with difficulty in walking and carrying out daily activities. He did not give any other systemic complaints or have other comorbid illnesses. A family history of similar lesions was not present. He had taken topical therapies including phototherapy without much benefit. Examination revealed the presence of waxy yellowish scaly palmoplantar keratoderma involving the bilateral palms and soles diffusely with extension onto the dorsum [Figure 1a and b]. The nails were dystrophic with transverse ridging, increased curvature, and subungual hyperkeratosis. Thus, considering the possibility of hereditary palmoplantar keratoderma genetic testing for clinical exome was done which revealed a mutation in the SLURP1 gene (Exon 3, c.212G>A, [p.Arg71His]), thus confirming the diagnosis of Mal de Meleda.

Mal de Meleda is a rare autosomal recessive palmoplantar keratoderma due to a mutation of the SLURP1 gene. First described in the Croatian island of Mljet, it is characterized by diffuse yellowish waxy palmoplantar keratoderma, nail dystrophy, periorificial plaques, and psoriasiform lesions, along with transgradiens and progradiens. Complications include superadded fungal infections causing malodor, mutilation with pseudoainhum formation, melanoma, and squamous cell carcinoma. Treatment options include topical keratolytic such as urea, lactic

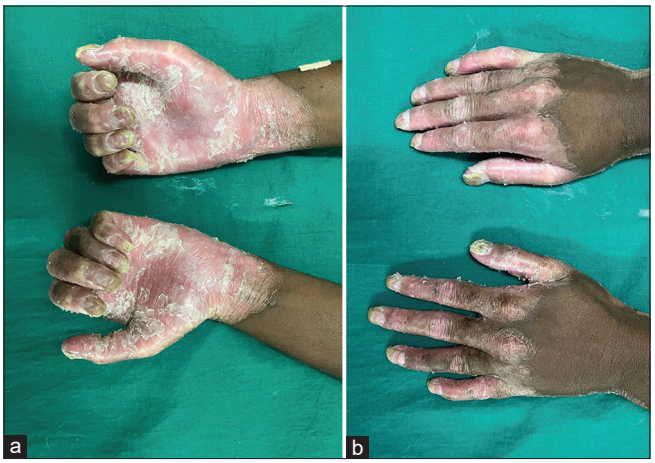

Figure 1: (a) Diffuse waxy keratoderma involving the palms in a glove shaped fashion. (b) Presence of transgradiens with nail dystrophy.

acid, and salicylic acid, systemic agents such as acitretin and alitretinoin have also been used.[1]

Declaration of patient consent

The authors certify that they have obtained all appropriate patient consent.

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Nil.

Conflicts of interest

There are no conflicts of interest.

REFERENCE

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