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Generalities of Keratosis Pilaris

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Introduction

Keratosis Pilaris (KP) is a common benign skin disorder of follicular hyperkeratosis; generally begins in the first or second decade of life, affecting almost 50 to 80% of all adolescents and approximately 40% of adults, it can cause psychosocial distress due to cosmetic appearance [1,2,3]. It has an autosomal dominant inheritance pattern, there are studies that show a deletion of chromosome 18p, which may be related to an alteration in the functioning of the LAMA 1 gene (encoding laminin alpha, which is present in the skin annexes) located in this chromosome, possibly being important in the formation of sebaceous glands, and manifesting as a possible prominent and extensive keratosis pilaris [2].

The pathogenesis of keratosis pilaris is not very clear, but the most accepted theory proposes that it is produced by a defective keratinization of the follicular epithelium that results in a keratotic infundibular plug (keratin plug) [2,3]. KP is mainly characterized by the presence of follicular keratotic papules, associated or not with basal erythema in the affected areas; small papules give the skin a stippled appearance that resembles chicken skin. In addition, it can affect all surfaces of the skin where hair grows; however, it is most common in the upper arms (92%), thighs (59%), and buttocks (30%) [2].

Discussion

Most of these patients are asymptomatic, unaware of the disorder, and it is often an incidental finding on physical examination [3]. The diagnosis of KP is purely clinical, based on the history and findings in the physical examination; generally the biopsy is not necessary for its diagnosis. Evaluation using a dermatoscope is often helpful in diagnosis, where the presence of frequently coiled or semicircular hairs, perifollicular erythema, and peripilar casts can be seen [4,5].

Keratosis Pilaris is associated with several conditions, studies have shown a correlation with atopic dermatitis. However, KP has no diagnostic significance for it; in fact, KP occurs much more frequently in patients with ichthyosis vulgaris without eczema than in patients with atopic dermatitis [3]. Ichthyosis vulgaris is an abnormal keratinization disorder characterized by the appearance of the skin becoming dry and scaly, the affected areas are generally the extensor aspects of the upper and lower extremities without affecting the flexion folds; the ichthyosis vulgaris frequently associated with KP is hereditary ichthyosis vulgaris [5].

There are rare variants and rare subtypes of KP, including pityriasis pilaris rubra, erythromelanosis follicularis faciei et colli, and the spectrum of keratosis pilaris atrophicans. Pityriasis rubra pilaris is characterized by follicular keratosis, palmoplantar erythroderma, and keratoderma. On the other hand, erythromelanosis follicularis faciei et colli is characterized by erythema, hyperpigmentation, and follicular papules; these papules are grouped into well-defined reddish-brown areas that impart a granular texture to the skin [5]. Likewise, atrophic keratosis pilaris is a term used to describe a set of related disorders characterized by keratosis pilaris, followed by atrophy [3].

It tends to progressively clear up on its own and with age (roughly in the 16-year range), but some patients may have symptoms that worsen over time. There is no definitive treatment, however, measures can be taken to reduce symptoms, such as adequate hygiene, in order to improve appearance and thus quality of life [1]. It is very common to use topical treatments, which include emollients and keratolytics. Skin texture improves with the use of a 6% salicylic acid lotion or a 20% urea cream [4]; Topical tretinoin therapy can also be given, especially when other treatments have not been adequate. If the KP lesions are marked by substantial inflammation, mild topical steroids may be beneficial; Preparations such as 0.1% triamcinolone acetonide or 0.05% desonide creams can be applied until inflammation improves, usually within 7 days, then the patient must discontinue steroids and manage KP with skin softening therapies. Other less common treatment options include laser treatments and vitamin D3 derivatives, which are very effective [1,3,5].

Conclusion

In conclusion, keratosis pilaris is a common hereditary skin condition, generally asymptomatic, that occurs very commonly in the first and second decade of life. It is characterized by small folliculocentric keratotic papules that may have surrounding erythema. Its diagnosis is clinical and the objective of its treatment is to reduce symptoms and improve the physical appearance of the lesion.

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