Ichthyosis with confetti (IWC) (OMIM 609165), also referred to as congenital reticular ichthyosiform erythroderma or ichthyosis variegata, is a genodermatosis, first described as ichthyosé en confetti in 1984. It is a rare disease, with only 9 and 13 patients being clinically and genetically documented to date, respectively (cited in Burger et al3,4). Patients are first noticed as collodion babies or as having a generalized extensive erythema. Histological findings are epidermal thickening in the ichthyotic skin and a disordered differentiation of keratinocytes with parakeratosis; ultrastructure shows perinuclear shells. The ichthyotic phenotype persists throughout life. During childhood, however, numerous confetti-like patches of pale, healthy-appearing skin begin to form, increasing in size and number with age. Histological examination confirms that the skin in these spots is indeed normal. Appearance of healthy skin spots often suggests the correct diagnosis. The adult cutaneous manifestation of IWC is a generalized scaly erythroderma interspersed with hundreds to thousands of confetti-like patches of healthy skin, palmoplantar keratoderma, and dorsal acral hypertrichosis (cited in Burger et al3 and Diociaiutiet al7).

The ichthyotic phenotype appears to result from dominant mutations in the gene encoding keratin 10 (KRT10). Individuals affected by IWC all carry small heterozygous deletions, insertions, or duplications toward the 3′ end of KRT10. This produces a frameshift, and consequently mutated proteins in such patients contain an arginine-rich C-terminus. In the patches of healthy skin, however, the disease-causing mutation has reverted to the wild-type sequence through copy-neutral loss of heterozygosity.3,4 The size of the healthy patches suggests that loss of heterozygosity occurs in the progenitor cells of an epidermal stem cell unit during early embryonic development; however, its exact mechanism and timing is unknown.

Herein, we present clinical data from 6 unrelated patients, together with details of their individual mutations in KRT10. Genetic data were also obtained from a seventh individual, the twin sister of one of the patients, who was not studied clinically. We observed several ectodermal malformations, which are clearly associated with the disease and underline its syndromic nature. The aim of the clinical investigations was to determine novel major and minor criteria for
diagnosis of IWC, both before and after the appearance of healthy skin spots. An analysis of the disease locus in 17 control individuals was conducted to identify novel genetic polymorphisms in the general population.

Methods

No concern was raised by the Ethikommission beider Basel, Basel, Switzerland, and the Ethical Committee Fondazione IRCCS Ca Granda, Milan, Italy.

Seven patients with IWC from Italy and Switzerland were included in this study. Patients, or parents of minor patients, provided written informed consent for all investigations. All patients were clinically investigated, with the exception of patient 7, the monozygotic twin sister of patient 6; according to her family, the phenotype of patient 7 is very similar to that of her sister. Clinical examination of all patients was by 2 dermatologists (G.T. and P.H.I.), both experts in genodermatoses. Patient 3 has previously been described clinically,2,8,9 and patient 4 has been described clinically and genetically.3,6

All 7 patients with IWC and some of their parents or siblings were analyzed genetically, as well as 17 unrelated control subjects from the general population. Genetic mutations were identified by direct sequencing of KRT10 from genomic DNA extracted from whole blood, as previously described.3

Clinical features that were clearly and consistently associated with the condition were defined as major criteria. Clinical features, which were not obligatory present in every patient, were defined as minor criteria.

Results

The individuals described in this study include 7 patients with IWC, 6 female and 1 male, from 6 unrelated families. Patients ranged from children to adults. We characterized the following major criteria, which are apparent clinical diagnostic features of the disease (Table 1; Figure 1 and Figure 2; and eFigure 1 in the Supplement). All patients had a history of erythroderma from birth, with the appearance of healthy skin spots during childhood. Four patients showed hyperpigmentation within these spots, which seems to be independent of sun exposure (Table 1 and eFigure 1G in the Supplement). Furthermore, all patients showed epidermal scaling and dorsal acral hypertrichosis, limited to the areas of ichthyotic skin (Table 1; Figure 1A; and eFigure 1A in the Supplement). Affected hairs were dark (which had turned white in 1 patient) and relatively thick in all patients, irrespective of skin type. Two female patients reported an unusually fast growth of these hairs. Further major criteria included several ectodermal malformations. Hypoplasia of mammillae was observed in all patients, and malformed ears were observed in 5 patients (Table 1; Figure 1C; and eFigure 1B, C, and G in the Supplement). Unfortunately, because this last feature was not immediately apparent, it was not investigated in 1 patient who could not be recalled to the clinic within the time frame of this study.

Minor criteria (Table 1; Figure 1 and Figure 2; and eFigure 1 in the Supplement) were not present in all of the 6 patients investigated clinically. Nevertheless, they may give important hints for correct diagnosis in future patients. All but 2 patients were born as collodion babies. Lunulae were notably large and the nail plates were elongated in 5 patients (Table 1; Figure 1E; and eFigure 1F in the Supplement). Malformation of nails (unguis in-flexus), palmoplantar hyperkeratosis, and ectropion of the eyelids were present in 4 patients (Table 1; Figure 1D; and eFigure 1D and E in the Supplement). Decreased finger length relative to palms and joint contractions of the fingers were apparent in 3 patients (Table 1; Figure 1D; and eFigure 1D and E in the Supplement). Although scalp hair was normal in all patients, 3 patients had reduced eyebrows and eyelashes. Strabismus was present in 3 patients and nystagmus in 2 patients. Teeth were normal in all patients, and none reported increased or reduced sweating or blistering. All patients had a small height and weight relative to their age. The relevance of this remains to be verified, however, by normalization of patient parameters with parental height and weight. In the absence of this significant information, we listed this feature as a minor criterion.

Findings from a detailed investigation of the skin pattern showed that healthy spots were not distributed equally across the skin but followed a gradient, being largest and at greatest density in the neck, décolleté, and scapular regions; fewer and smaller on arms and legs; and almost absent from the face. In 1 adult patient, the skin on the legs showed a patchy, dark brown hyperpigmentation and a verrucous appearance (Figure 1B); these features have been reported in another study of an elderly female patient.5

The general impression at clinical assessment was that patients are affected in very individual ways. Generally, skin problems seem to improve with age. All patients but one are receiving long-term systemic acitretin (retinoic acid) treatment.

Patients’ parents and siblings were not affected by IWC, with the exception of patient 7, the monozygotic twin of patient 6. Sequencing of KRT10 from each patient revealed different, heterozygous mutations, which are causative for IWC (Table 2 and eFigure 2 in the Supplement). Two unrelated patients carried different, single base-pair (bp) mutations in the intron 6 splice acceptor site of KRT10; both are predicted to produce an alternative splice site (http://www.umd.be/HSF/) similar to previously described cases of IWC causing mutations4,7 and, consequently, a frameshift in the DNA sequence. Four patients carried small insertions and deletions within exon 7. Consistent with previous reports, all mutations reported herein caused a frameshift in the sequence predicted to be translated into mutant proteins with an arginine-rich C-terminus. Alignment of predicted protein sequences revealed that the arginine-rich sequence varied in length between different patients and contained a consensus sequence of 55 amino acids (eFigure 3 in the Supplement). Consequently, the aberrant keratin 10 protein (K10) is localized in the nucleus (data previously published9).

We sequenced the same locus from unaffected parents or siblings of patients and from 17 unrelated control individuals from the general population. We did not detect the
<table>
<thead>
<tr>
<th>Patients, No./Total No. (%)</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pathological mutation</td>
<td>c.1374-1G&gt;A</td>
<td>c.1374-1G&gt;C</td>
<td>c.1506_1507delAA</td>
<td>c.1546_1551delinsT</td>
<td>c.1557_1558delLG</td>
<td>c.1573_1574dupA</td>
</tr>
<tr>
<td>Age at clinical examination</td>
<td>Child</td>
<td>Young adult</td>
<td>Adult</td>
<td>Adult</td>
<td>Child</td>
<td>Young adult</td>
</tr>
<tr>
<td>Sex</td>
<td>Female</td>
<td>Male</td>
<td>Female</td>
<td>Female</td>
<td>Female</td>
<td>Female</td>
</tr>
<tr>
<td>Major Criteria</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Erythroderma since birthb</td>
<td>6/6 (100)</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Current IWC (Figure 1 and eFigure 1 in the Supplement)</td>
<td>6/6 (100)</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Scaling with changing severityb</td>
<td>6/6 (100)</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Appearance of healthy spots, age, yb</td>
<td>6/6 (100)</td>
<td>7</td>
<td>12-13</td>
<td>10</td>
<td>10-12</td>
<td>7</td>
</tr>
<tr>
<td>Dorsal acral hypertrichosis (Figure 1A and eFigure 1A in the Supplement)b</td>
<td>6/6 (100)</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Hypoplasia of mammillae (eFigure 1G in the Supplement)</td>
<td>6/6 (100)</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Malformation of ears (Figure 1C and eFigure 1B and C in the Supplement)b</td>
<td>5/5 (100)</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>Not investigated</td>
</tr>
<tr>
<td>Minor Criteria</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Collodion babyb</td>
<td>4/6 (80)</td>
<td>+</td>
<td>+</td>
<td>−</td>
<td>−</td>
<td>+</td>
</tr>
<tr>
<td>Unguis inflexus (eFigure 1F in the Supplement)b</td>
<td>5/6 (83)</td>
<td>+</td>
<td>−</td>
<td>+</td>
<td>+</td>
<td>−</td>
</tr>
<tr>
<td>Large lunulae/long nail plates (Figure 1E and eFigure 1F in the Supplement)b</td>
<td>5/6 (83)</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>−</td>
</tr>
<tr>
<td>Palmoplantar hyperkeratosis (Figure 1D and eFigure 1D in the Supplement)b</td>
<td>4/6 (67)</td>
<td>+</td>
<td>−</td>
<td>−</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Hyperpigmentation in healthy spots (eFigure 1G in the Supplement)</td>
<td>4/6 (67)</td>
<td>−</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>−</td>
</tr>
<tr>
<td>Ectropion of eyelidsb</td>
<td>4/6 (67)</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>−</td>
</tr>
<tr>
<td>Strabismus</td>
<td>3/6 (50)</td>
<td>−</td>
<td>+</td>
<td>+</td>
<td>−</td>
<td>−</td>
</tr>
<tr>
<td>Reduced eyebrows and lashes</td>
<td>3/6 (50)</td>
<td>+</td>
<td>−</td>
<td>−</td>
<td>+</td>
<td>−</td>
</tr>
<tr>
<td>Decreased finger length relative to palm (Figure 1D and eFigure 1D and E in the Supplement)</td>
<td>3/6 (50)</td>
<td>−</td>
<td>−</td>
<td>+</td>
<td>+</td>
<td>−</td>
</tr>
<tr>
<td>Nystagmus</td>
<td>2/6 (33)</td>
<td>−</td>
<td>+</td>
<td>−</td>
<td>+</td>
<td>−</td>
</tr>
<tr>
<td>Pruritusb</td>
<td>2/6 (33)</td>
<td>+</td>
<td>−</td>
<td>+</td>
<td>−</td>
<td>−</td>
</tr>
<tr>
<td>Involvement of scalpb</td>
<td>2/6 (33)</td>
<td>Scaling alopecia</td>
<td>Strong scaling</td>
<td>−</td>
<td>−</td>
<td>−</td>
</tr>
<tr>
<td>Joint contractions (eFigure 1E in the Supplement)b</td>
<td>2/6 (33)</td>
<td>−</td>
<td>−</td>
<td>+</td>
<td>+</td>
<td>−</td>
</tr>
<tr>
<td>Short stature relative to ageb</td>
<td>6/6 (100)</td>
<td>109 cm (below −3 SD)</td>
<td>170 cm (15th percentile)</td>
<td>160 cm (25th percentile)</td>
<td>153 cm (fourth percentile)</td>
<td>137 cm (37th percentile)</td>
</tr>
<tr>
<td>Low weight relative to ageb</td>
<td>5/5 (100)</td>
<td>16 kg (below third percentile)</td>
<td>58 kg (10th percentile)</td>
<td>48 kg (18th percentile)</td>
<td>45 kg (10th percentile)</td>
<td>28 kg (10th percentile)</td>
</tr>
</tbody>
</table>

Abbreviations: +, present; −, absent.

* Patients are numbered according to the position of their pathological mutation. Data concerning normal weight and size, used to provide a comparison, were obtained from recent percentile tables from patients’ countries of origin.

** Clinical features, already reported in different patients than the ones described here.
heterozygous frameshift mutations responsible for IWC in any of these individuals; however, we found 6 common in-frame sequence variants that occurred independently of IWC. Two of these were novel (Table 3): an in-frame deletion of 15 bp (c.1521_1535del15) and a triplication of 30 bp (c.1654_1683tri30). These variants occurred independently of each other in the heterozygous state in 1 of 17 control individuals (minor allele frequency [MAF] = 0.029/1). Of 17 control individuals, 8 (MAF = 0.235/8) were heterozygous for a different, recently published variant (c.1468_1479del12).7

Discussion

The skin pattern of IWC directly reflects a process of self-healing resulting from the spontaneous loss of a dominant pathological mutation during mitosis.3-4 The clinical spectrum of symptoms and the features and development of the disease give important insight into its underlying mechanisms. As patients are born with severe skin symptoms, K10 may be important during prenatal skin development. Alternatively, mutant K10 might execute a dominant negative effect, as suggested by the effect of autosomal dominant mutations in Krt10 in a mouse model for epidermolytic ichthyosis. Although mice heterozygous for a targeted mutation in Krt10 were clearly affected,10-11 Krt10 (−/−) mice had an essentially normal epidermis,11 suggesting that loss of a given keratin is less detrimental than the presence of a mutant one.

Evidence for prenatal expression of K10 in humans is scarce. Dale et al12 found expression of K10 in the fetal intermediate skin layer from week 9 of fetal development. Malformation of the ears, present in 5 patients described in this study and mentioned by Elbaum et al13 and Diociaiuti et al,7 might indicate an influence of K10 or mutant K10 from around week 6 of development, when formation of the ear is initiated. Alternatively, aberrant cornification might disturb auricle formation, as it is observed in some collodion babies and other severe disorders of cornification (eg, Harlequin fetus). In the context of scaling erythema, malformation of the ears may represent a key sign of IWC, allowing correct diagnosis before the characteristic skin pattern has evolved (Figure 2). Hypoplasia of mammillae is also strongly connected to the disease (Table 1 and eFigures 1 and 2 in the Supplement). Although this major feature has not been previously noted, it is visible on published pictures of other patients with IWC.5,14

An association between different ichthyoses and hypertrichosis has been only sporadically reported; thus, hypertrichosis appears to be a specific phenotype of IWC. It is limited to areas of ichthyotic skin, and thus may be triggered by inflammation and hyperemia, as has been hypothesized, for example, in postcard hypertrichosis.

The unequal distribution of healthy spots across the integument indicates an additional, unknown influence in their development, possibly a factor involved in growth or blood circulation.

An intriguingly similar pattern of ichthyotic and healthy skin is observed in patients with pityriasis rubra pilaris. Pityriasis rubra pilaris usually occurs sporadically, being triggered by some unknown factor. Hypothetically, there is a common underlying mechanism for the 2 diseases; as in IWC, the induced erythema might unmask skin areas with a different genetic composition.

Systemic acitretin improves disease symptoms in most patients with IWC. Systemic retinoids decrease cell proliferation while increasing cell differentiation. Interestingly, they have been shown to down-regulate KRT10 expression.15 Sequencing of KRT10 from patients with IWC revealed that the intron 6 splice acceptor site was affected in 6 of the 15 genetically described kindreds (eFigure 2 in the Supplement). Moreover, this locus is highly repetitive and showed considerable genetic variation in 17 disease-free individuals, pointing to increased plasticity in this DNA region. The sequence variants are all in-frame and not related to overt disease; however, we did not test whether any of these polymorphisms were
correlated with subclinical phenotypes, such as, for example, a tendency for dry skin. These results suggest a mutation hot spot in this particular section of DNA.

Alignment of the predicted proteins produced by mutated KRT10 showed an arginine-rich consensus sequence of 55 amino acids (eFigure 3 in the Supplement). Because nuclear localization signals frequently contain clusters of basic amino acid residues, this might underlie the observed mislocalization of mutated protein into the nucleus.3,4

Conclusions

A detailed clinical investigation of several patients with IWC enabled us to identify major and minor disease criteria for the first time. Among these are ectodermal malformations, which point to an influence of K10 during prenatal development and suggest reclassification of IWC as a genetic syndrome.
Dermatologic Etymology
Primary Morphology of Skin Lesions

Robert Denison Griffith, MD; Leyre A. Falto-Aizpurua, MD; Keyvan Nouri, MD

A cutaneous disease can be classified according to its primary morphology (Greek. μορφή, -morphē, form) + -logia, a discourse, science, the study of).1,2

Macule (Latin. macula, spot)1
Patch (French. pieche, piece)1,2
Papule (Latin. papula, swelling)1,2
Plaque (Dutch. plak<plakken, tablet or plate)1,2
Nodule (Latin. nodulus<nodus, knot)1,2
Vesicle (Latin. vesica<vesica, little bladder or blister)1
Bulla (Latin. bulla, bubble)1,3
Pustule (Latin. pustula, pimple)1,2
Abscess (Latin. òb, away from + cedere, to go).1,3 Note: abscessus, a departure, perfect participle of abscedere, to go away. It was thought that evil humors within the body make a mass and depart through suppuration (Latin. suppurationem<suppurare, to discharge pus).1

Echymosis (Greek. εκχύσωσεν, ekkhumōsis < ekkhumonathai, escape of blood)1,2

Purpura (Greek. ῥοζρύπα, porphyra, purple pigment)3
Telangiectasia (Greek. τέλος, tēlos, end + ἀγγείον, angeion, vessel + ἔκτασις, ekktasis, dilatation).1,2

Erythrodema (Greek. ἐρυθρός, eruthrōs, red + δέρμα, derma, skin or hide)1,2

Milium (Latin. milium, millet, a small seed)2,3

Author Affiliations: Department of Dermatology and Cutaneous Surgery, University of Miami Miller School of Medicine, Miami, Florida.

Corresponding Author: Robert Denison Griffith, MD, Department of Dermatology and Cutaneous Surgery, University of Miami Miller School of Medicine, 1475 NW 12th Ave, Second Floor, Miami, FL 33136 (r.griffith@med.miami.edu).


REFERENCES


