specially the eruptive form, may represent a paraneoplastic manifestation since it has been described in association with hematopoietic malignancies or solid organ tumours (i.e., hepatocellular carcinoma, cholangiocarcinoma, ovarian cancer) [3-6]. The typical histological feature of porokeratosis is the cornoid lamella, which corresponds to the border between normal epidermis and the clone of mutant keratinocytes. Prognosis of porokeratosis is generally good but some cases of squamous cell carcinoma developed on porokeratosis have been described, suggesting porokeratosis as a possible pre-cancer situation. Proposed treatments are photodynamic therapy, local tacalcitol or Acitretinoin for disseminated variants [2,3].

Conclusion

No data have been reported so far about the link between porokeratosis and exemestane or trastuzumab. As the patient is still receiving the same oncological treatment, persistence of the lesions could be linked with either the immunotherapy or the anti-hormonal therapy. Porokeratosis is a disorder of keratinization and antibodies targeting the HER-family receptors can cause disorders at this level. The possibility that eruptive porokeratosis must be considered as a paraneoplastic phenomenon in our case cannot be completely ruled out. Nevertheless, the long period of time between both conditions, the fact that skin eruption persists although tumour response to the treatment and a time association with the treatment starting supports a drug induced phenomenon in our opinion.

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