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Autoinflammatory keratinization diseases: an emerging concept encompassing various inflammatory keratinization disorders of the skin

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HIGHLIGHTS

• The term autoinflammatory keratinization diseases has been proposed as an umbrella term for inflammatory keratinization disorders with autoinflammatory pathomechanisms.
• Integral diseases entities include IL36RN-related pustulosis, CARD14-mediated pustular psoriasis, pityriasis rubra pilaris type V and keratosis lichenoides chronica.
• Improved understanding of disease pathophysiology may lead to innovative targeted therapies.

ABSTRACT

Classifying inflammatory skin diseases is challenging, especially for the expanding group of disorders triggered by genetic factors resulting in hyperactivated innate immunity that result in overlapping patterns of dermal and epidermal inflammation with hyperkeratosis. For such conditions, the umbrella term “autoinflammatory keratinization diseases” (AIKD) has been proposed. AIKD encompasses diseases with mixed pathomechanisms of autoinflammation and autoimmunity, and includes IL-36 receptor antagonist (IL-36Ra)-related pustulosis, CARD14-mediated pustular psoriasis, pityriasis rubra pilaris (PRP) type V, and familial keratosis lichenoides chronica (KLC). Mechanistically, the entities include generalized pustular psoriasis (GPP) without psoriasis vulgaris, impetigo herpetiformis and acrodermatitis continua, which are IL-36Ra-related pustuloses caused by loss-of-function mutations in IL36RN; GPP with psoriasis vulgaris and palmoplantar pustular psoriasis which are CARD14-mediated pustular psoriasiform dermatoses with gain-of-function variants of CARD14; PRP type V which is caused by gain-of-function mutations in CARD14; and, familial KLC in which mutations in NLRP1, an inflammasome sensor protein predominantly expressed in skin, have been identified. It is likely that further inflammatory keratinization disorders will also fall within the concept of AIKD, as elucidation of novel pathogenic mechanisms of inflammatory keratinization diseases emerge. A better understanding of the pathophysiology of AIKD is likely to lead to innovative, targeted therapies that benefit patients.

Abbreviations used:
AIKD: autoinflammatory keratinization diseases
CAPS: cryopyrin-associated periodic syndrome
CARD14: caspase recruitment domain family member 14
FMF: familial Mediterranean fever
GPP: generalized pustular psoriasis
IL-36Ra: IL-36 receptor antagonist
KLC: keratosis lichenoides chronica
NLRP1: NLR family Pyrin domain-containing protein 1
PAPA syndrome: syndrome of pyogenic arthritis with pyoderma gangrenosum and acne
PRP: pityriasis rubra pilaris
PV: psoriasis vulgaris
TLR4: toll-like receptor 4
TRAPS: TNF receptor-associated periodic fever syndrome

Key words: autoinflammation, CARD14, IL-36 receptor antagonist, keratinization, keratosis lichenoides chronica, NLRP1, pityriasis rubra pilaris, psoriasis, psoriatic arthritis, pustular psoriasis

1. Introduction

Among the myriad diseases affecting the skin are a subset of disorders whose main pathobiology is inflammation, predominantly in the epidermis and the superficial dermis, that leads to hyperkeratosis, manifesting clinically as thickened scaly skin. These are designated as “inflammatory keratinization disorders”. The category includes many conditions that are poorly defined, although some, including psoriasis and lichen planus, are better categorized.

Nevertheless, the pathogenic mechanisms of most inflammatory keratinization disorders remain unresolved. However, new pathogenic mechanisms relating to autoinflammation have been demonstrated in some inflammatory keratinization disorders, providing unexpected mechanistic insights and new ideas for targeted therapies. In 2017, we proposed a new umbrella term,
“autoinflammatory keratinization diseases” (AIKD), to encompass inflammatory keratinization disorders with autoinflammatory pathogenic mechanisms [1]. We herein summarize the concept of AIKD, review the diseases included in this disease subgrouping, and discuss the clinical value of grouping conditions as AIKD.

2. What are AIKD?

Our initial concept paper on AIKD defined the disease entities as having four inclusion criteria [1]: (1) the primary and main inflammation sites are the epidermis and the upper dermis; (2) the inflammation leads to hyperkeratosis, which is the main and characteristic phenotype of AIKD; (3) AIKD have primary genetic causative factors associated with the hyperactivation of innate immunity (autoinflammation), mainly in the epidermis and the upper dermis; (4) the spectrum of AIKD encompasses diseases with mixed pathomechanisms of autoinflammation and autoimmunity. Of note, in AIKD, genetic abnormalities leading to hyperactivation of the innate immune system predominantly are implicated in disease pathogenesis. In contrast, in inflammatory keratinization diseases without autoinflammatory pathogeneses (inflammatory keratinization diseases, non-autoinflammatory), no apparent genetic background susceptibility has been identified in most cases and the innate immune system involvement is not as significant. Points of differentiation between AIKD and inflammatory keratinization diseases, non-autoinflammatory are summarized in Table 1. To date, disorders included in AIKD comprise: IL-36 receptor antagonist (IL-36Ra)-related pustulosis, caspase recruitment domain family member 14 (CARD14)-mediated pustular psoriasis, pityriasis rubra pilaris (PRP) type V and keratosis lichenoides chronica (KLC) (Table 2) [1, 2]. As the causes and predisposing factors for inflammatory keratinization diseases come to be clarified, further disorders are also likely to be included in the AIKD category. For example, lichen planus, which may be triggered by factors such as medications, trauma or viruses, is currently regarded as non-autoinflammatory, yet new data on inflammasome pathology in other lichenoid diseases may lead to future reassignment of
lichen planus to within the AIKD grouping. (See the discussion below on NLR family Pyrin domain-containing protein 1, NLRP1).

3. IL-36RA-related pustulosis

In 2011, Marrakchi et al. [3] reported that IL36RN mutations leading to IL-36Ra deficiency were present in nine Tunisian families with recessively inherited familial generalized pustular psoriasis (GPP). IL36RN mutations were also reported as a genetic cause in three sporadic European GPP patients [4] and a Japanese GPP patient [5] (Fig. 1A, B). Subsequently, it was established that most sporadic GPP patients without preceding or concomitant psoriasis vulgaris (PV) skin lesions have IL36RN mutations as genetic predisposing or causative factors for the disease [6, 7]. Patients with certain other psoriasis-related pustular diseases including acrodermatitis continua of Hallopeau [8], severe acute generalized exanthematous pustulosis [9] and impetigo herpetiformis [10], have been reported to have IL36RN mutations as a genetic predisposing or causative factor.

IL-36α, IL-36β and IL-36γ are absent in non-inflammatory skin, but they are generated by stimuli of inflammatory cytokines including TNF-α and IL-17A [11]. IL-36α, IL-36β and IL-36γ are activated differentially by the neutrophil granule-derived proteases cathepsin G, elastase and proteinase-3, resulting in up to a 500-fold increase in their biological activities [12]. IL-36α, IL-36β and IL-36γ activate several pro-inflammatory signaling molecules including NFκB [13]. The skin is the primary and main expression site of IL-36Ra. Mainly in the skin, IL-36Ra antagonizes the interleukin-1 family members IL-36 α, β and γ [14, 15]. In this context, IL-36Ra deficiency caused by loss-of-function mutations in IL36RN is considered to induce and accelerate IL-36-driven inflammation in the skin [15]. Recently, Il36rn−/− mice treated with a toll-like receptor 4 (TLR4) agonist were reported to show autoinflammatory symptoms in the skin, joints and liver; such mice have been established as a model of IL36Ra-deficient GPP [16].
4. CARD14-mediated pustular psoriasis

Psoriasis, one of the most common inflammatory keratinization disorders, is a chronic multifactorial inflammatory disease involving the skin, nails and joints [17]. The most common plaque-type psoriasis is psoriasis vulgaris (PV). Various inflammatory keratinization disorders such as psoriatic arthritis, GPP and palmoplantar pustular psoriasis (palmoplantar pustulosis) are known to be psoriasis-related diseases [18]. Recently, Arakawa et al. [19] demonstrated that melanocyte antigens can trigger autoimmunity in chronic PV, indicating that psoriasis has autoimmunity aspects and that acquired immunity may play a pathogenic role in psoriasis. In addition, it is widely accepted that psoriasis is a Th17-mediated disease rather than an inflammasome-driven one. This categorization is convincingly demonstrated by the much greater clinical efficacy of Th17-targeted biologics than IL-1-neutralizing therapies in PV. In light of this, inflammatory keratinization in psoriasis is not completely autonomous. However, psoriasis has innate and adaptive immune mechanisms implicated in its pathogenesis. Christophers et al. [20] suggested that, chronologically, in early or highly active lesions of psoriasis, inflammation begins as IL-1-TNF-mediated, neutrophil-dominant inflammation that induces Th17-dominant, early T-cell infiltration that develops into a Th1-dominant psoriasis plaque. This perspective remains controversial. For example, one recent publication identified IL-12 as a psoriasis-protective factor [21]. Furthermore, psoriasis is a group of highly heterogeneous diseases. Thus, autoimmunity and autoinflammation might be relevant to the inflammatory processes to different degrees in each clinical subset of psoriasis [22].

Recently, it has been documented that CARD14 gain-of-function variants/mutations may be risk factors for PV and psoriatic arthritis [23, 24]. Of note, the heterozygous CARD14 mutation, p.Gly117Ser, was identified in a large family with familial PV [23]. In addition, the rare de novo gain-of-function CARD14 variant p.Glu138Ala was reported in a sporadic patient with severe early-onset GPP [23]. Another rare CARD14 variant, p.Asp176His, was revealed to be a
significant risk factor for GPP with preceding or concomitant PV lesions, and was shown to underlie approximately 20% of GPP cases with PV in the Japanese population (compared to 3.0% in Japanese controls) [25]. In addition, concerning palmoplantar pustular psoriasis (palmoplantar pustulosis), CARD14 variants are thought to be a disease risk factor in European patients [26]. Autosomal dominant familial GPP caused by a CARD14 mutation was recently reported [2]. These data show that various phenotypes are seen in patients carrying CARD14 variants/mutations, with clear pathogenic implications for these findings in psoriasis and related diseases.

CARD14 encodes the CARD family member CARD14. CARD14 is regarded as a scaffold protein regulating the signaling pathway of NF-κB [23, 27, 28]. CARD14 is mainly expressed and localized in epidermal keratinocytes [23, 27]. In reports by Jordan et al., [23, 24] transfection experiments and studies using keratinocyte cell lines from patients with CARD14 mutations revealed that psoriasis-predisposing CARD14 mutations hyperactivate NF-κB and accelerate the expression of certain psoriasis-associated genes in keratinocytes. Recently, CARD14 has been reported to form a signaling complex with BCL10 and the paracaspase MALT1, and psoriasis-associated CARD14 mutations were revealed to enhance this process in keratinocytes [29, 30]. These findings support the notion that, in inflammatory keratinization diseases associated with CARD14 mutations, the CARD14 mutations are involved in disease pathology in epidermal keratinocytes, although we cannot completely rule out the possibility that effects of CARD14 mutations in immune cells may be partly responsible for disease pathogenesis.

5. Pityriasis rubra pilaris (PRP)

In addition, the concept of AIKD can also be applied to CARD14 mutation-driven inflammatory keratinization diseases, such as PRP type V. PRP is an inflammatory keratinization disease that shows general follicular plugging and perifollicular erythema with confluent configurations [31]. Pityriasis capitis and palmoplantar keratoderma are also seen in PRP [31]. In 1980, PRP was
classified into five subgroups, types I to V, based on clinical criteria (age of onset, distribution of lesions, disease course) [31]. The types are classical adult type (type I), atypical adult type (type II), classical juvenile type (type III), circumscribed juvenile type (type IV) and atypical juvenile type (type V). A further subtype, associated with HIV infection (PRP type VI), has been reported [32]. Patients with PRP are mostly sporadic cases [33]. However, familial cases have also been reported, mainly in PRP type V [33]. Indeed, this particular subtype of PRP differs somewhat from the other variants. Patients with type V PRP show skin symptoms from infancy or early childhood and usually have a chronic course without any long-standing resolution of the skin features. In 2012, gain-of-function mutations in \textit{CARD14} were reported to underlie familial PRP cases with autosomal dominant inheritance [27]. We recently reported that all PRP type V patients in our series of PRP cases had \textit{CARD14} mutations (Fig. 1C-E) [34]. Furthermore, the symptoms and disease course of PRP patients who were reported to have \textit{CARD14} mutations were scrutinized, and notably, all the previously reported PRP patients harboring \textit{CARD14} mutations were clinically classified as PRP type V [34]. In contrast, among patients with the other types of PRP, no \textit{CARD14} mutations were found, although a few \textit{CARD14} variants were observed in some patients [34]. Currently, nine heterozygous \textit{CARD14} mutations have been reported in type V PRP patients [27, 34-37]. In light of the above, PRP type V, the atypical juvenile type, is thought to be a distinct variant of PRP with \textit{CARD14} mutations [34], and we propose that PRP type V is an AIKD.

6. Familial keratosis lichenoides chronica (KLC)

KLC is an infrequently seen inflammatory keratinization disorder. Kaposi first described KLC in 1895, but the term KLC was formally proposed by Margolis in 1972 [38]. Patients with KLC show multiple small papules with confluent, linear and reticulate configurations on the trunk and extremities. KLC patients may also have seborrheic dermatitis-like eruptions on the face, palmoplantar keratoderma and hypertrophic nail deformities. These skin lesions are usually asymptomatic, but typically show chronic and frequently progressive courses.
Histopathologically, lichenoid interface dermatitis with numerous necrotic keratinocytes and parakeratosis are seen in lesional skin [38]. For a long time, the cause of KLC was unknown. Very recently, a gain-of-function mutation in NLRP1, the gene that encodes the inflammasome sensor protein NLRP1 was reported to underlie familial KLC in one family (Fig. 1F, G) [39]. Thereafter, one family and one sporadic patient with NLRP1 mutations were reported to have autoinflammation symptoms including follicular keratosis in the skin, as well as polyarthritis [40].

NLR proteins patrol the cytosol and initiate inflammasome assembly, pyroptotic cell death, and pro-inflammatory cytokine release upon ligand binding [41, 42]. Aberrant activation of inflammasomes is known to be pathogenic in a group of autoinflammatory syndromes with germline-activating mutations in inflammasome sensor proteins [43]. Another member of the NLR family of inflammasome sensor proteins, NLRP3 is well known as the causative molecule of the autoinflammatory syndrome cryopyrin-associated periodic syndrome (CAPS) [44].

NLRP1 was revealed to be one of the most highly produced inflammasome sensor proteins in the skin, and other components of inflammasomes, such as CASP1, ASC, IL-1β and IL-18, are also expressed in epidermal keratinocytes [39]. It was elucidated that wild-type NLRP1 retains its form as an inactive monomer by the combined action of the pyrin domain and a leucine-rich repeats domain. The KLC-causing mutation reported disrupts the leucine-rich repeats domain and part of the linker region, leading to constitutive NLRP1 self-oligomerization and inflammasome activation [39]. Excessive activation of inflammasomes and IL-1 secretion has been demonstrated in patient keratinocytes, and inflammasome-dependent IL-1 cytokines have been shown to cause the inflammatory familial KLC [39]. Thus, autoinflammation is thought to work in the pathogenesis of KLC, at least in that of familial KLC. Further studies are expected to yield information on similar pathogenic mechanisms associated with inflammasome signaling in sporadic KLC cases.
Therapies based on the pathomechanisms of AIKD

Recently, various therapies based on the pathomechanisms of AIKD have achieved sufficient efficacy in several kinds of AIKD.

Neutrophils are thought to be frequently involved in the inflammatory reaction induced in AIKD (Fig. 2). Thus, granulocyte and monocyte adsorption apheresis is expected to be effective for AIKD cases. Indeed, the treatment efficacy of granulocyte and monocyte adsorption apheresis was reported in a GPP case that resulted from an IL36RN mutation [45].

Concerning molecularly targeted therapies for GPP patients with IL-36Ra-related pustulosis, a successful therapy with the IL-1 receptor antagonist anakinra was reported in a patient with GPP caused by IL36RN mutations [46]. The IL-1 pathway is generally involved in the pathogenesis of AIKD (Fig. 2). In GPP with IL36RN mutations, the IL-1 pathway is downstream of the inflammatory reaction induced by IL-36 (Fig. 2). Thus, it is conceivable that the blockade of IL-1 signaling is effective against GPP resulting from IL36RN mutations. TNF-α is also generally involved in the inflammatory pathways in the pathogenesis of AIKD (Fig. 2), and infliximab, a monoclonal anti-human TNF-α antibody, was reported to be effective in sibling cases of GPP with IL36RN mutations [47].

Furthermore, IL-12/IL-23 and IL-17 are thought to be involved in the inflammatory cascades that have been implicated in the pathogenesis of AIKD, including GPP with IL36RN mutations and PRP with CARD14 mutations (Fig. 2). In fact, the therapeutic efficacy of ustekinumab, a monoclonal anti-human IL-12/IL-23 p40 antibody, was suggested in GPP patients with and without IL36RN mutations [48]. Beneficial effects of ustekinumab were reported also in patients with PRP caused by CARD14 mutations [35, 37]. In addition, response to IL-17 inhibition was observed in an adolescent GPP patient with IL-36Ra deficiency [49].
Although sufficient information has not been obtained concerning treatments for KLC resulting from \textit{NLRP1} mutations, anakinra seems to have some effectiveness in patients with \textit{NLRP1}-associated autoinflammation with arthritis and dyskeratosis [40]. KLC-causative \textit{NLRP1} mutations are known to overactivate inflammasomes and IL-1 secretion, resulting in the KLC phenotype [39] (Fig. 2). Thus, the IL-1 receptor antagonist anakinra is assumed to be effective as a treatment for KLC with \textit{NLRP1} mutations.

In light of the above-mentioned findings, molecularly targeted therapies directing chemokines/cytokines and signal molecules involved in the inflammatory pathways of AIKD pathogenesis are promising, novel treatments for AIKD [16]. In this context, understanding the pathophysiology of severe inflammatory keratinization diseases with autoinflammatory pathogeneses, based on the recognition that they are AIKD, may give us significant clues to innovate highly effective, novel targeted therapies.

\textbf{8. Conclusions and future perspectives}

In 2017, the disease terminology AIKD was proposed for inflammatory keratinization disorders with autoinflammatory mechanisms as their main etiology (Fig. 2) [1]. The clinical entity of AIKD contains certain PRP type V, KLC, and subgroups of psoriasis-related diseases as described above (Table 2).

The data summarized indicate that certain subsets of psoriasis and diseases related to it have genetic causes and predisposing factors associated with autoinflammatory mechanisms, such as \textit{CARD14} variants/mutations and \textit{IL36RN} mutations. AIKD featured the hyperactivation of innate immunity (autoinflammation) resulting from genetic causative/predisposing factors as the predominant pathogenic mechanism. The concept of AIKD includes diseases with mixed
autoinflammation and autoimmune mechanisms, as opposed to purely autoinflammatory diseases such as familial Mediterranean fever (FMF) and CAPS (Table 3). In light of this, we think that rare subtypes of psoriasis and disorders related to it [50] (i.e., GPP, impetigo herpetiformis and acrodermatitis continua with *IL36RN* mutations) and GPP and palmoplantar pustular psoriasis (palmoplantar pustulosis) with *CARD14* variants all fit within the category of AIKD. Furthermore, regarding the content of AIKD, although autoinflammatory mechanisms play a significant role in the inflammatory keratinization of the epidermis, we do not think that all the inflammatory processes need to manifest completely in epidermal keratinocytes in order for a disease to be categorized as an AIKD.

Most conventional autoinflammatory diseases/syndromes are known to have skin symptoms. Their skin manifestations are various and include urticarial eruptions, erythema nodosum-like lesions and pustular acne. FMF shows erysipelas-like erythema, and CAPS often has urticarial eruptions. TNF receptor-associated periodic fever syndrome (TRAPS) shows migratory, urticarial erythema and purpuric macules. Blau syndrome/early onset sarcoidosis has granulomatous dermatitis, and the syndrome of pyogenic arthritis with pyoderma gangrenosum and acne (PAPA syndrome) shows pustular acne and pyoderma gangrenosum. However, inflammatory eruptions with hyperkeratosis are uncommon in patients with conventional autoinflammatory diseases/syndromes. Therefore, while AIKD have autoinflammatory pathogenic mechanisms, AIKD are thought to cause distinctive inflammation that encompasses epidermal keratinocytes, leading to hyperkeratosis (Table 3).

Recent advances in medical genetics have revealed genetic causes/predisposing factors for a number of inflammatory keratinization disorders of the skin whose etiology has long been unknown. Such new insights into the pathogeneses of these inflammatory keratinization disorders has established the novel disease concept of AIKD. We expect that more inflammatory keratinization disorders will be classified as AIKD in the future, as better elucidation of novel
pathogenic mechanisms of inflammatory keratinization diseases emerges. The identification of further genetic causes and disease susceptibility factors and the correct evaluation of their significance to disease pathogeneses promise to provide clues for further understanding the pathophysiology of AIKD and for developing innovative and more targeted therapies for the protean collection of autoinflammatory syndromes.

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**Conflict of interest**
The authors declare no conflict of interest.

**Conflicts of interest:** None declared

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Short biography of Prof. Masashi AKIYAMA

Masashi Akiyama (M.D., Ph.D.) is a Professor and Chairman of the Department of Dermatology, Nagoya University Graduate School of Medicine, Nagoya, Japan from 2010. He received the M.D. in 1986 and Ph.D. in 1991 from Keio University, Tokyo, Japan. He was assigned as a Senior Research Fellow at University of Washington, Seattle (1992-1994) and an Associate Professor at Teikyo University Ichihara Hospital, Chiba, Japan (1999-2001). He served as an Assistant Professor (2001-2007) and an Associate Professor (2007-2010) at Hokkaido University, Sapporo, Japan.

His research is in the field of genodermatosis, genetic and autoinflammatory keratinization diseases, skin barrier function and its related allergic diseases.
Figure legends

Fig. 1. Clinical features of AIKD patients.
Characteristic clinical features of GPP with *IL36RN* mutations (A, B), PRP type V with *CARD14* mutations (C-E) and familial KLC caused by *NLRP1* mutations (F, G). Pustules and scaly hyperkeratosis are seen on erythrodermic skin on the chest and abdomen of an 18-month-old male (A) and on the lower leg of a 61-year-old male (B). Diffuse erythema with fine scaling is observed on the trunk (C) and on the legs (D) of a 20-year-old male. Severe hyperkeratosis with erythema is present on the palm of a 24-year-old female (E). A 10-month-old male infant shows seborrheic dermatitis-like eruptions on the face (F). A 10-year-old female patient has multiple small hyperkeratotic papules of reticulate configuration on the wrist (G).
Fig. 2. Inflammatory pathways involved in the pathogenesis of AIKD. Causative inflammatory pathways in the patients with IL-36Ra deficiency and gain-of-function mutations in CARD14 and NLRP1 are summarized. Up-regulated IL-36 signaling due to IL-36Ra deficiency (red starburst patterns) and gain-of-function mutant CARD14 (red arrows with blue starburst pattern) accelerate NFκB activity, resulting in the secretion of the chemokines/cytokines IL-36, IL-8, CXCL1, CXCL2 and CCL20 by keratinocytes. The chemokines/cytokines induce the activation of neutrophils and dendritic cells in the superficial dermis. In addition, gain-of-function mutants of NLRP1 hyperactivate NLRP1 inflammasomes (blue starburst pattern) in keratinocytes, leading to the secretion of IL-1β and IL-18 and resulting in the activation of the paracrine signaling network in the epidermis and the superficial dermis. Black arrows: secretion or activation; green arrows: cell differentiation or chemotaxis; ⊥: inhibition.
Table 1 Summary of the differences between autoinflammatory keratinization diseases (AIKD) and inflammatory keratinization diseases, non-autoinflammatory

<table>
<thead>
<tr>
<th>Points of differentiation between the two concepts</th>
<th>Autoinflammatory keratinization diseases (AIKD)</th>
<th>Inflammatory keratinization diseases, non-autoinflammatory</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pathogeneses</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Genetic causative factors</td>
<td>CARD14, IL36RN, NLRP1</td>
<td>none or unknown</td>
</tr>
<tr>
<td>Pathogenic mechanisms and pathways</td>
<td>mainly autoinflammation (hyperactivation of innate immunity) (mixture of autoinflammation and autoimmunity)</td>
<td>mainly autoimmunity (hyperactivation of acquired immunity) (Th17-mediated inflammation in psoriasis)</td>
</tr>
<tr>
<td><strong>Clinical features</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family history</td>
<td>common</td>
<td>rare</td>
</tr>
<tr>
<td>Disease course</td>
<td>often persistent for life</td>
<td>transient, or persistent for life</td>
</tr>
<tr>
<td>Extracutaneous symptoms</td>
<td>occasional (arthritis, cholangitis)</td>
<td>occasional (arthritis)</td>
</tr>
<tr>
<td>Treatments</td>
<td>Systemic treatments including immunosuppressants and biologics are often necessary.</td>
<td>Topical treatments are often effective. Systemic treatments are needed in some cases.</td>
</tr>
<tr>
<td>Representative diseases</td>
<td>GPP, PRP type V, KLC</td>
<td>psoriasis (the majority of cases), lichen planus</td>
</tr>
</tbody>
</table>
Table 2 Inflammatory keratinization diseases classified as AIKD to date

<table>
<thead>
<tr>
<th>Disease</th>
<th>Genetic causative or predisposing factor (frequency)</th>
</tr>
</thead>
<tbody>
<tr>
<td>IL36Ra-related pustulosis</td>
<td></td>
</tr>
<tr>
<td>generalized pustular psoriasis (GPP) without PV</td>
<td>IL36RN mutations (predominant)</td>
</tr>
<tr>
<td>impetigo herpetiformis</td>
<td>IL36RN mutations (predominant)</td>
</tr>
<tr>
<td>acrodermatitis continua</td>
<td>IL36RN mutations (occasional)</td>
</tr>
<tr>
<td>CARD14-mediated pustular psoriasis</td>
<td></td>
</tr>
<tr>
<td>GPP with PV</td>
<td>CARD14 variants (occasional)</td>
</tr>
<tr>
<td>palmoplantar pustular psoriasis (palmoplantar pustulosis)</td>
<td>CARD14 variants (occasional)</td>
</tr>
<tr>
<td>Pityriasis rubra pilaris (PRP)</td>
<td></td>
</tr>
<tr>
<td>PRP type V</td>
<td>CARD14 mutations (predominant)</td>
</tr>
<tr>
<td>PRP other types</td>
<td>CARD14 variants (infrequent)</td>
</tr>
<tr>
<td>Keratosis lichenoides chronic (familial)</td>
<td>NLRP1 mutation (unknown)</td>
</tr>
<tr>
<td>Points of differentiation</td>
<td>Autoinflammatory keratinization diseases (AIKD)</td>
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<td>---------------------------</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td><strong>Pathogeneses</strong></td>
<td></td>
</tr>
<tr>
<td>Main sites of inflammation</td>
<td>skin (epidermis and upper dermis)</td>
</tr>
<tr>
<td>Pathogenic mechanisms</td>
<td>hyperactivation of innate immunity and related activation of acquired immunity (autoinflammation + autoimmunity)</td>
</tr>
<tr>
<td>Main inflammation pathways involved</td>
<td>CARD14/IL-36-driven NFκB/MAPK activation, NLRP1-inflammasome-IL-1 pathway</td>
</tr>
<tr>
<td><strong>Phenotypes</strong></td>
<td></td>
</tr>
<tr>
<td>Skin symptoms</td>
<td>hyperkeratosis with/without pustulosis (main phenotype)</td>
</tr>
<tr>
<td>Extracutaneous symptoms</td>
<td>arthritis, cholangitis, fever (additional phenotypes)</td>
</tr>
<tr>
<td>Representative diseases</td>
<td>GPP, PRP type V, KLC</td>
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