Solitary plaque in the perianal region

Sir,

Bowen's disease is a premalignant dermatosis mostly affecting the sun-exposed sites. It usually develops in response to certain predisposing factors. We hereby report a case of an elderly gentleman with perianal Bowen's disease.

A 58-year-old farmer presented with a pruritic scaly patch over the lower back, present for the preceding 1 year. To start with, the lesion was a coin-sized patch, which gradually increased in size, and the patch began to ooze over the past 2 months. He sought treatment for this condition to multiple physicians, but there was no improvement. There was no history of pain, mucosal lesions, or any other skin lesions. On examination, a well-defined, erythematous, moist crusted plaque (7 cm × 5 cm) was present in the lumbosacral region [Figure 1]. There was no locoregional lymphadenopathy, and no similar lesions were found elsewhere in the body. Routine investigations were within normal limits, and the patient was seronegative for HIV. Systemic examination was unremarkable. Based on the clinical findings, differential diagnosis of Bowen's disease, psoriasis, extramammary Paget disease, and wart was made. Skin biopsy was performed from the lesion which showed marked epidermal hyperkeratosis, irregular acanthosis, scattered atypical keratinocytes, nuclear pleomorphism, and inflammatory infiltrate in the upper dermis [Figures 2 and 3]. On the basis of clinicopathological correlation, a diagnosis of Bowen's disease was made, and the patient was treated with complete surgical excision followed by full-thickness skin grafting.

Bowen's disease affects skin and mucosa. Since it is a premalignant condition, if untreated, it may develop into invasive squamous cell carcinoma.[1] Clinically, it is manifested with a solitary erythematous scaly papule which gradually enlarges to form a crusted moist plaque. It is usually found on the sun-exposed sites, most

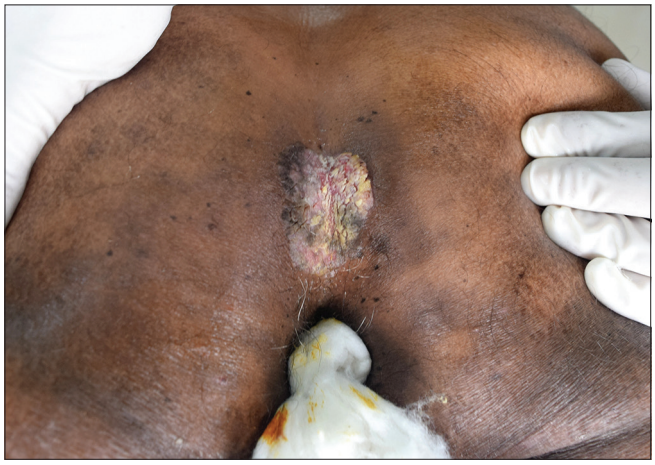

Figure 1: Solitary moist plaque in the lumbosacral region

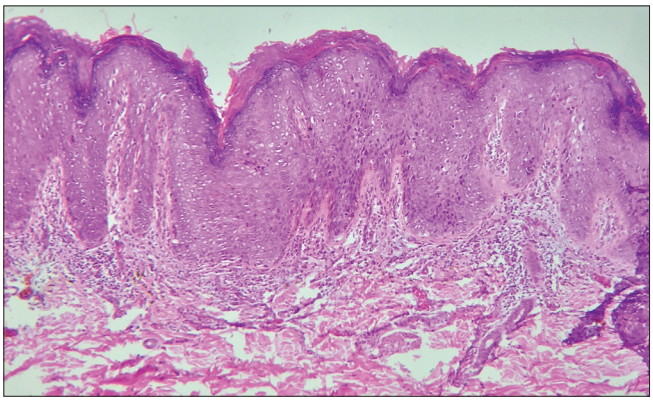

Figure 2: Epidermal hyperkeratosis, irregular acanthosis, scattered atypical keratinocytes, nuclear pleomorphism, and inflammatory infiltrate in the upper dermis (H and E, ×100)

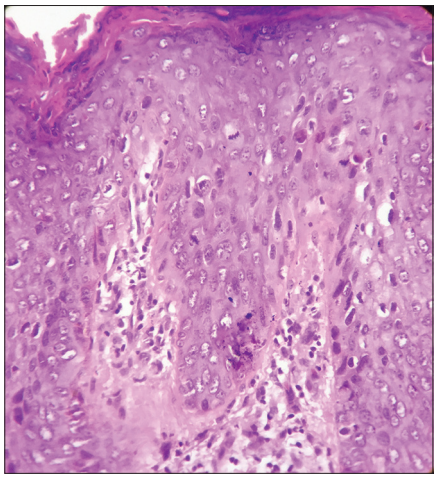

Figure 3: Scattered atypical keratinocytes with mitotic figures and nuclear pleomorphism (H and E, ×400)

commonly head, neck, and extremities though covered areas can also get involved.[2,3] Variants include pigmented, subungual, periungual, palmar, genital, perianal, verrucous, etc.[4] Histologically, atypical forms may be seen such as psoriasiform, atrophic, acantholytic, epidermolytic, and pagetoid.[5]

The etiopathogenesis of the condition remains unclear, but predisposing factors include chronic sun exposure, arsenic exposure, and human papillomavirus (16, 18, 31, 33, 39, and 52). Histology shows hyperkeratosis, parakeratosis, and elongated rete ridges. The keratinocytes are haphazardly arranged throughout the epidermis giving a "windblown appearance." Besides, the cells show atypia with large hyperchromatic nuclei.[5]

The prognosis of Bowen's disease is favorable. There are only 5% chances of progression to invasive squamous cell carcinoma. Therapeutic modalities include topical agents such as 5-fluorouracil and imiquimod, surgery, curettage, cautery, and cryotherapy.[6,7]

We are reporting this case for the presence of lesion in the sun-protected area (perianal region) without any evidence of anal intercourse, immunosuppression, and arsenic exposure.

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Conflicts of interest

There are no conflicts of interest.

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