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Giant perianal Seborrheic keratosis: A case report

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ABSTRACT

INTRODUCTION: Seborrheic keratosis is one of the most common benign epidermal cutaneous lesions encountered by dermatologists and plastic surgeons in their daily practice.
PRESENTATION OF THE CASE: A 66-year-old man was presented with a large verrucous mass on the sacrum and perianal area of 10 years duration. After the diagnosis of SK was confirmed, a complete excision of the lesion was done with coverage of the defect with a partial thikness skin graft, with a good outcome.
DISCUSSION: Giant Seborrheic keratosis are very rare, and their location on the perianal area is rarer still, with no more than 10 published cases of genital area involvement.
CONCLUSION: Giant perianal seborrheic keratoses is a very rare presentation, that may resemble many of the skin disease of that area and should be managed with excision and biopsy to confirm the diagnosis.

1. Introduction

Seborrheic keratosis(SK) is a benign skin lesion that can be described to be the most common skin lesion in the elderly population; itsformation is due to the rapid proliferation of the keratinocytes of the skin, Usually at sun exposed areas. Although it is a very common disease, the presentation of a perianal giant lesion is rare contributing to limited options of treatments. Here we present a case of a giant Seborrheic keratosis located at the perianal area that was successfully treated with good outcomes. This work has been reported in line with the SCARE criteria [1].

2. Report of the case

A 66-year-old man was presented with a large verrucous growth on the sacrum and perianal area of 10 years duration. The lesion started as a small pigmented verrucous papule on the sacrum, which slowly increased in size to become a large verrucous mass and in extent to involve the external genitalia of the anus. There was no pain or discharge. There was no history of sexual promiscuity in either spouse. A family history showed no skin disease or malignancy in the family.

On physical examination, a large, pigmented verrucous mass (of size around 15 × 10 cm) (Fig. 1). no evidence of cellulitis nor skin color changes around the lesion. Unremarkable inguinal lymph node examination.

We considered differential diagnosis of condyloma acuminata, Buschke Lowenstein, verrucous carsinom and giant SK. Dermoscopic examination was carried out, which showed cerebriform appearance, fissures, ridges, and comedo-like openings consistent with SK.

After the diagnosis of SK was confirmed, a complete excision of the lesion was done (Fig. 2) with coverage of the defect with a partial thikness skin graft (Fig. 3), with a good outcome (Fig. 4), The histopathologic examination of a biopsy sample showed epidermal hyperkeratosis and focal parakeratosis and extensive acanthosis and papillamotosis consistent of giant Seborrheic keratosis (Fig. 5). HPV was negative on biopsy material through the PCR method.

3. Discussion

SK is a common benign epidermal proliferation, first described in 1869, present as a well circumscribed, black, round elevated, “stuck on” skin lesions, increases with age. The lesions are more common in the sun-exposed areas except of palms,and soles [2].

According to the US National Health and Nutrition Examination Survey, about 23 million persons in the United States have seborrheic kératoses. The percentage of those affected is higher in the

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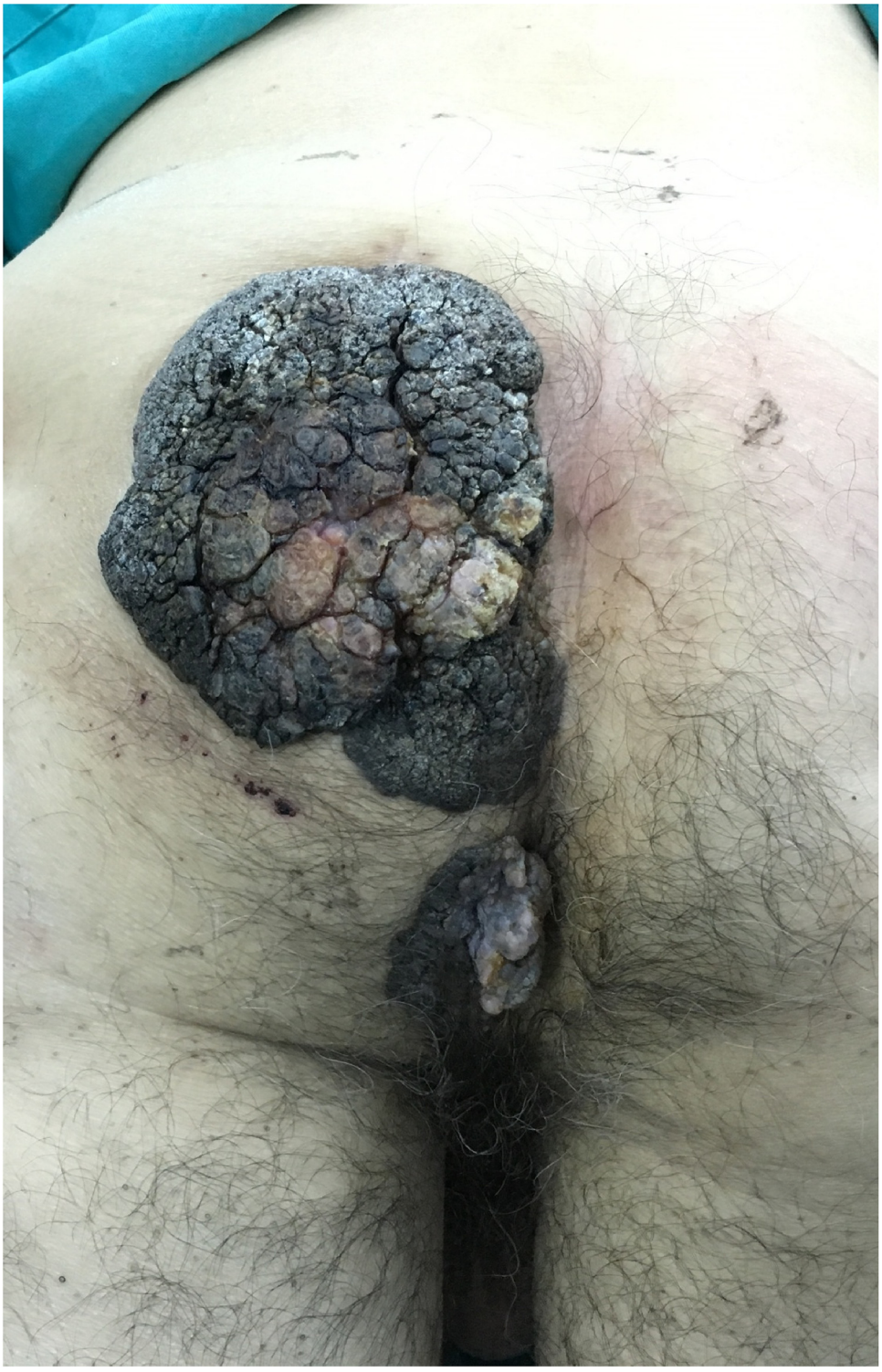

Fig. 1. a large, pigmented verrucous mass aroung the anus.

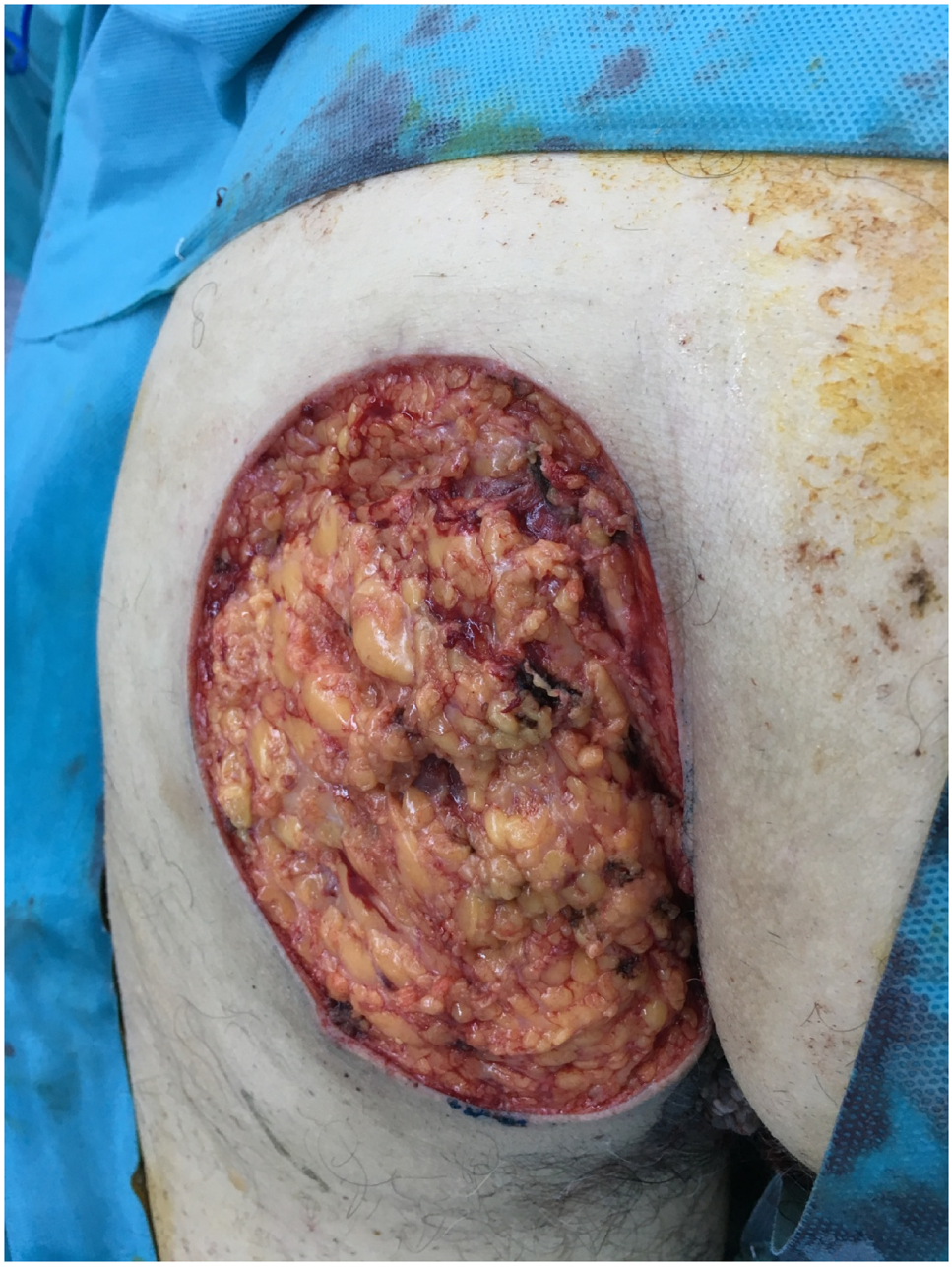

Fig. 2. full excision of the lesion.

older age groups, namely 18% in persons 55–64 years of age and 20% in persons 65–74 years of age. Men and women are affected equally. Seborrheic kératoses have been considered to be a nevoid anomaly, and when they occur in profuse form an autosomal dominant mode of inheritance has been proposed [9].

Different Morphologic variants are recognized for SK: the common flat type, skin tag like, stucco keratosis, dermatosis papulosa nigra, inverted follicular keratosis, and melanoacanthoma. Of these, the acanthotic subtype is the most common variant. More than one type is often found in the same lesion [7]. Basal cell carcinoma, condyloma acuminata, melanoma are the most common misdiagnoses of seborrheic keratosis [2–5].

SK involving the genital region is a rare scenario, and can be easily misdiagnosed as genital warts. Histopathology helps in making the diagnosis in such cases [3]. Lesions are rarely more than 3 cm in diameter. Seborrheic keratoses are more prevalent in individuals with skin phototype I and II. The participation of human papilloma viruses (HPVs) in pathogenesis of seborrheic keratoses is being considered [4].

Despite the high number of cases of seborrheic keratoses, the pathogenesis is still not completely Understood. Some authors believe in genetic predisposition and somatic mutations of particular Genes, which lead to the formation of seborrheic keratoses after sun exposure. It has been suggested that HPVs could play role in the pathogenesis of seborrheic keratosis. The cause of genital SK is as yet unknown, but there may be a possible role of chronic friction [3,4].

The clinical diagnosis of SK may be difficult at times with only 49% accuracy. in a study done by Stern et al. [2]. Diagnosis becomes

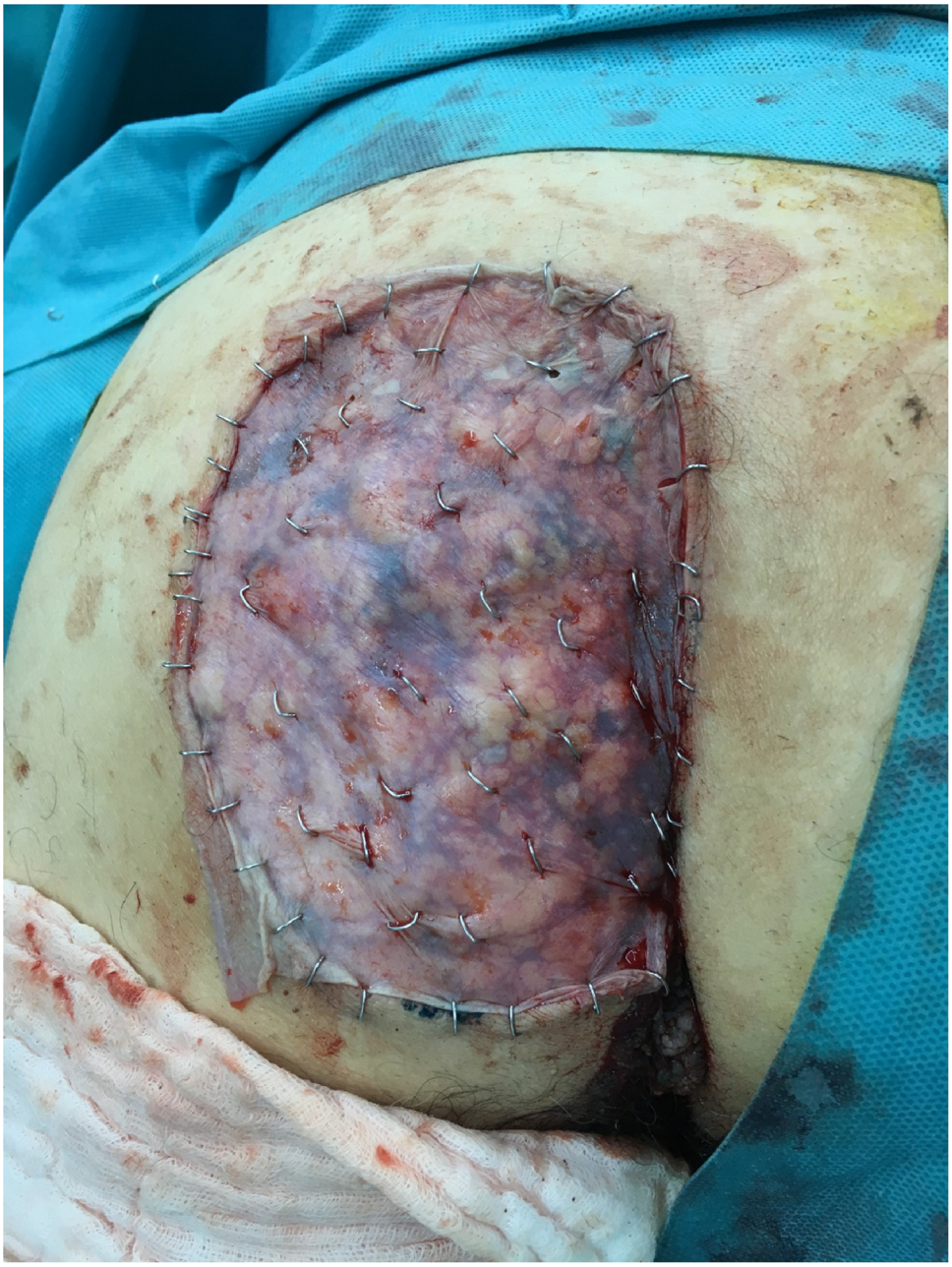

Fig. 3. split thickness skin graft applied at the area of excision.

more difficult in the genital region as the classical clinical features of SK (distinct keratotic and follicular plugging, stuck-on appearance, etc.) disappear because of the friction and maceration typical of this area [2].

Though malignant transformation is rare, it is reported in irritated lesions, especially in flexures. An unusual case of giant lobulated seborrheic keratoses occurring in perianal area, without any evidence of malignancy on histopathology, in an otherwise healthy obese female [9].

Bowen's disease is the most common neoplasm (7%) followed by basal cell carcinoma (4%) to be involved in such lesions, and up to 10% of excised lesions have a certain degree of atypia [5] histopathologically, SK and genital warts share some features in common and, occasionally, it is very difficult to differentiate between them. A specific diagnosis of C. acuminate can be made only when koilocytes (enlarged keratinocytes that contain an eccentric pyknotic nucleus surrounded by a wide halo) are identified [8].

The treatment of seborrheic keratoses is not mandatory; given the benign origin of the disorder.The most common treatment modality is cryotherapy with nitrogen liquid, curettage, laser or surgical shave, and other ablative methods. Some studies show good efficacy of topical administration of vitamin D and tazarotene which result in the induction of keratinocytes apoptosis [6] but cases of giant SK should be treated because of the risk of malignancy being harboured and because of the discomfort of the lesion [7].

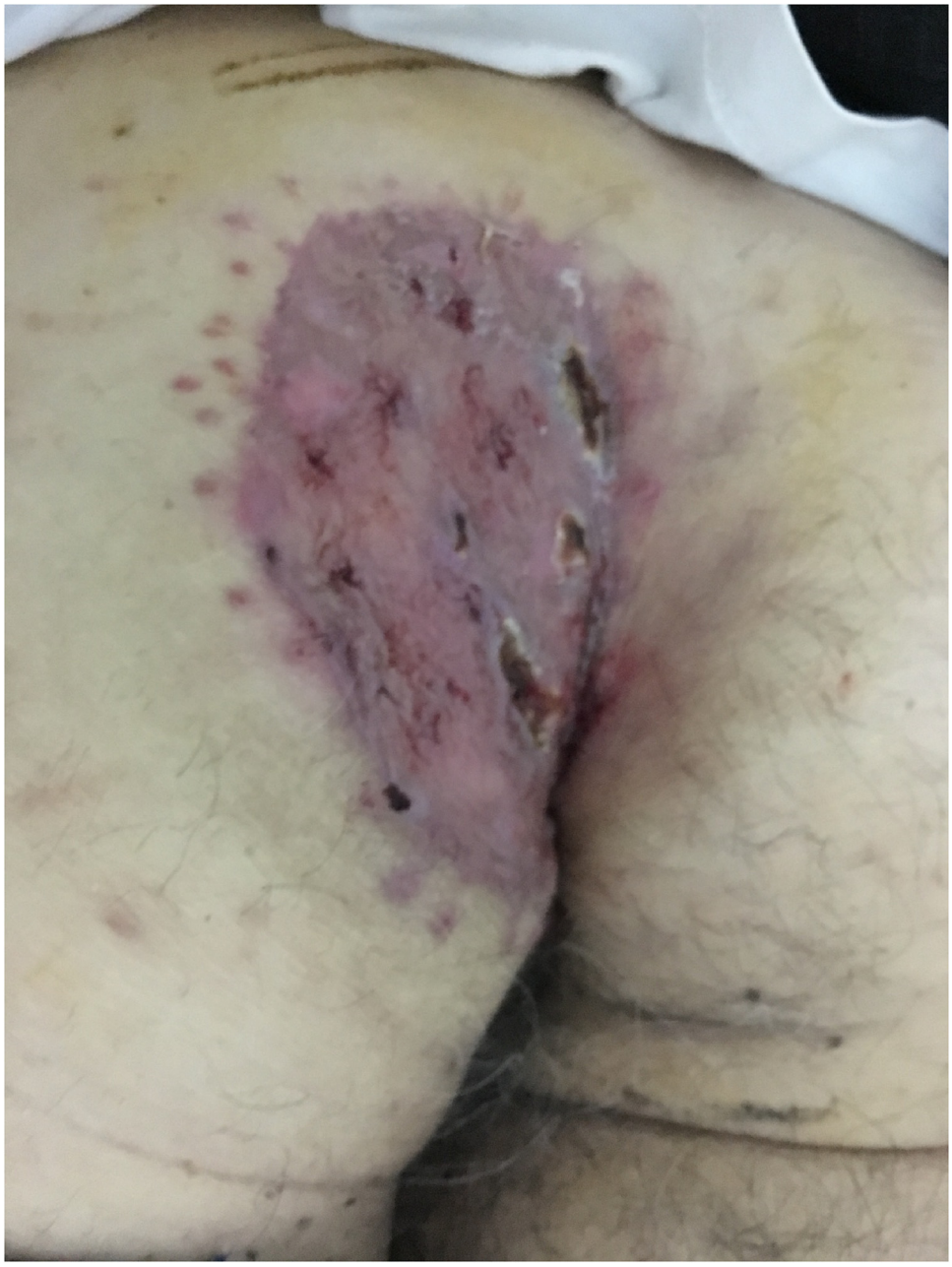

Fig. 4. the area of resection after 9 months.

4. Conclusion

Giant perianal seborrheic keratoses is a very rare presentation, that may resemble many of the skin disease of that area and should be managed with excision and biopsy to confirm the diagnosis.

Conflicts of interest

No conflict of interest.

Sources of funding

No funding.

Ethical approval

This article is approved by the ethics committee of Jordan University Hospital and IRP of the university of Jordan.

Consent

Written informed consent was obtained from the patient for publication of this case report and accompanying images. A copy of the written consent is available for review by the Editor-in-Chief of this journal on request.

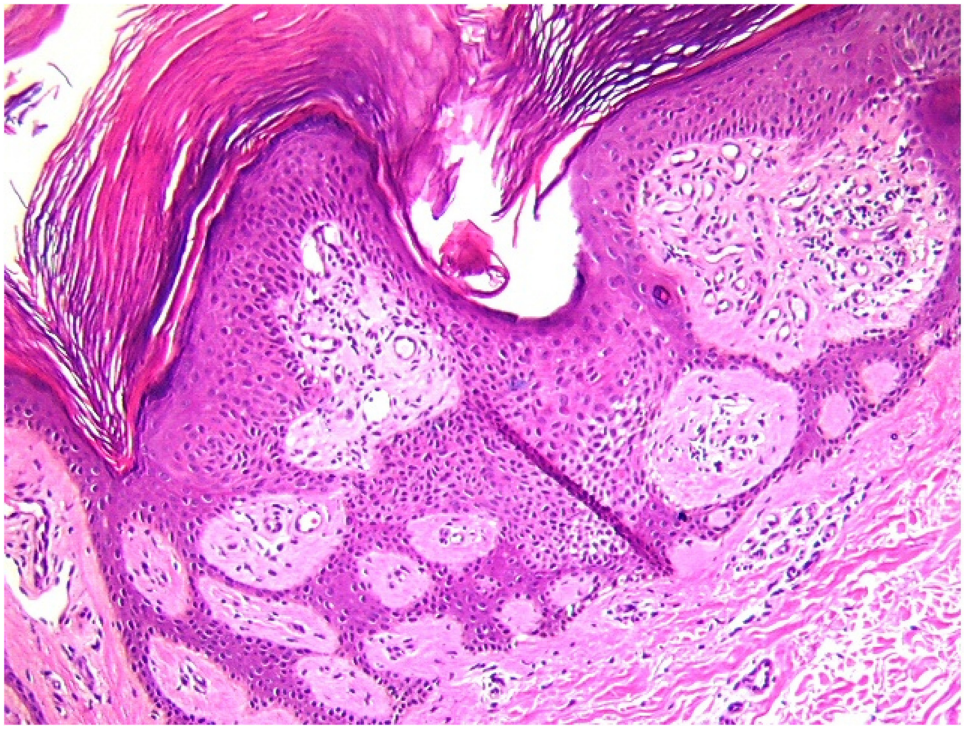

Fig. 5. histopathology of the specimen showing epidermal hyperkeratosis and extensive acanthosis and papillamotosis.

Author contribution

Bareq Salah MD., FRCS.(ed): writing and editing.
Mohamad Mahseer MD.: writing and editing and reviewing.
Zaid Al-Ali DDS., MFD., RCSI.: reviewing and editing.
Tareq aladwan: reviewing.
Ata Gaith: reviewing.
Bawth Al-Rawashdeh: reviewing.

Registration of research studies

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Guarantor

Bareqa Salah.

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