Extensive verrucous seborrheic keratosis mimicking deep mycoses

Sir,

A 55-year-old male farmer presented with asymptomatic, slowly progressive cauliflower-like growths initially appearing on back with subsequent involvement of other parts of body of 20 years duration. There was no preceding history of trauma, bleeding/discharge from lesions or any systemic complaints.

Physical examination revealed multiple skin colored and hyperpigmented soft non tender verrucous plaques and nodules of varying sizes, asymmetrically distributed over limbs and trunk predominantly, with little involvement of palms, soles and scalp [Figures 1-3]. Hair, nails and mucous membranes were normal.

Routine hematological investigations, liver, renal functions and chest X-ray were normal. Serology for HIV was negative. Repeated biopsies from lesions over back showed

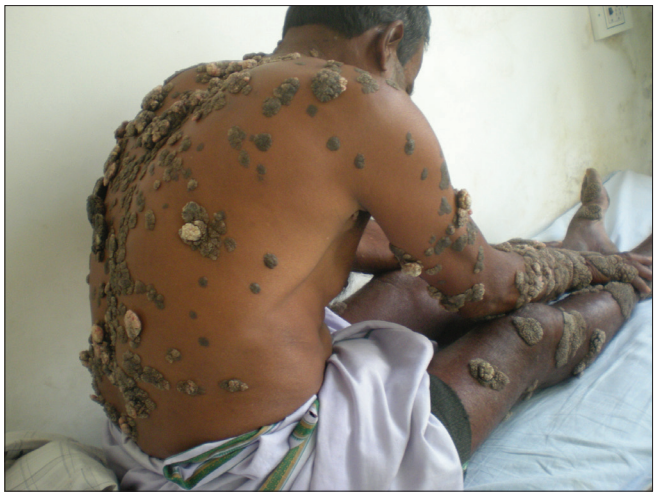

Figure 1: Verrucous plaques over trunk and limbs

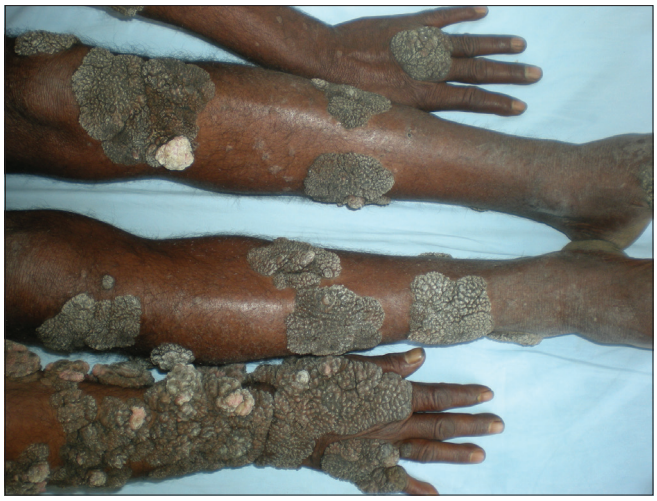

Figure 2: Verrucous plaques asymmetrically distributed over limbs

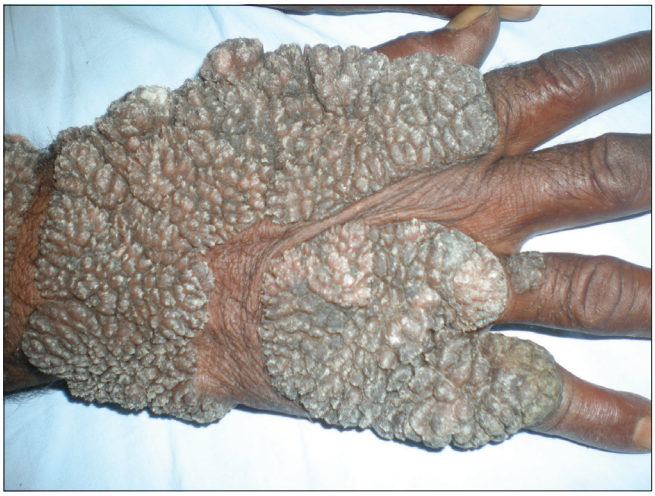

Figure 3: Close up of a lesion over hand

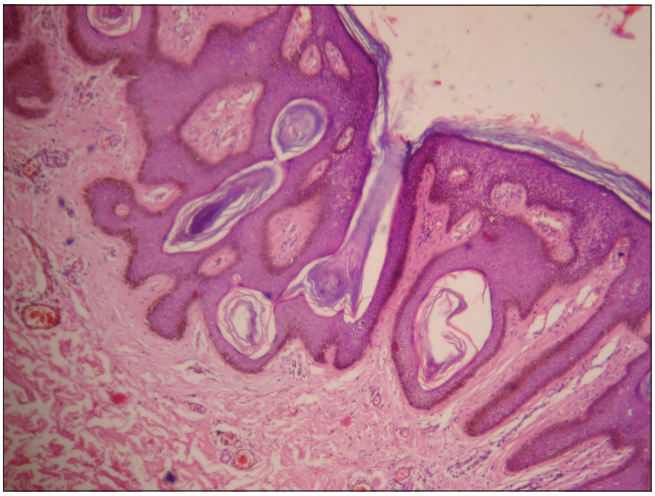

Figure 4: Histopathology showing hyperkeratosis, acanthosis and papillomatosis with horn cysts in epidermis (H and E, ×40)

hyperkeratosis, acanthosis and papillomatosis with good number of horn cysts in epidermis. Dermis showed capillary proliferation and mild lymphocytic infiltrates [Figure 4]. There was no evidence of malignancy, and staining for Acid fast bacilli and Periodic acid schiff was negative. Features were suggestive of acanthotic seborrheic keratosis.

Seborrheic keratosis is a common benign epithelial tumor of unknown etiology, which can arise anywhere on the skin but with the exception of palms and soles. The mucus membranes are also generally spared. Lesions may be solitary, but more often they are disseminated in large numbers, especially in older patients.[1]

Extensive truncal seborrheic keratosis in association of lepromatous leprosy has been documented.[2] Atypical presentations mimicking other dermatological disorders have also been observed. Giant perianal seborrheic keratosis mimicking Condylomata acuminata and pigmented seborrheic keratoses of the vulva clinically mimicking a malignant melanoma have been reported.[3,4] A case of seborrheic keratosis following Blaschko's lines has been published.[5] A giant lesion of seborrheic keratosis on perineal and scrotal areas in a mentally disabled young man complicated by myiasis has been reported recently.[6]

Seborrheic keratoses may be removed to exclude the presence of malignancy (if clinical findings are equivocal), to treat inflammation caused by irritation, or most commonly cosmetic reasons. The treatment of choice is removal of the lesion using one of various operative procedures currently available viz shave excision, crurettage, electrodessication, cryotherapy and ablative lasers. Despite some reports on topical (vitamin D analogs, tazarotene) and systemic (vitamin D analogs) drug therapy in seborrheic keratoses, such approaches have generally proven to be unsuccessful. Patients with a large

number of seborrheic keratoses, sometimes well over 100, present a particular challenge, if the patient wishes to have them removed given the limitations on performing multiple surgeries.[1]

Treatment option of surgical excision in multiple sittings was declined by the patient. Involvement of palms and soles and extensive verrucous seborrheic keratosis mimicking deep mycoses hitherto unreported were interesting observations in this therapeutically challenging case.

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