Giant perigenital seborrheic keratosis

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ABSTRACT

Seborrheic keratosis (SK) is a very common benign epidermal proliferation that is prevalent in all races. Most commonly occurring on the trunk, face, scalp, and the extremities, they can occur anywhere on the body except the palms and soles. The most common appearance is that of a very superficial verrucous plaque which appears to be stuck on the surface. Giant lesions are very rare, and their location on the genital area is rarer still. We report here a case of multiple giant SK lesions in a 59-year-old man.

Key words: Genital, giant, perigenital, seborrhoeic keratosis

Access this article online

Website: www.idoj.in

DOI: 10.4103/2229-5178.148939

Quick Response Code:

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INTRODUCTION

Seborrheic keratosis (SK) is an extremely common benign epidermal proliferative lesion, which is prevalent in all races. Most lesions are found on the trunk, face, scalp, and the extremities, although they can occur anywhere on the body except the palms and soles. Their number and size tend to increase with age. The most common appearance is that of a very superficial verrucous plaque which appears to be stuck on the surface, varying from dirty yellow to black in color.[1] Giant lesions are very rare, and their location on the genital area is rarer still, with no more than 10 published cases.[2] We report here a case of multiple giant SK lesions located on the genitals and the adjacent areas.

CASE REPORT

A 59-year-old man presented with large dark coloured growths over his lower abdomen, genitalia and the adjoining areas of 10 years duration. The disease started as small elevations over the penis and left groin. Over the next few years, new lesions appeared over the adjacent areas and grew in size to attain the present dimensions. The patient initially had local discomfort, occasional pain and irritation over the affected sites, but he was otherwise in good health. Past medical history was unremarkable and there was no family history of similar disease. The patient had not sought any medical consultation or treatment previously.

Examination revealed multiple, brownish black to black nodules, plaques, and tumors with lobulated, irregular, greasy surface [Figure 1]. In some areas, the lesions had erythematous moist erosions over the surface [Figure 2]. The lesions were distributed over the pubic area, penis, scrotum, groins, upper thigh, perineum, and the perianal areas. Some lesions were discrete, while the others were confluent, giving rise to large plaques. One lesion over the pubic area was pedunculated. Non-tender, mobile lymph nodes could be palpated over both inguinal areas. Other mucocutaneous areas were normal. Systemic examination was non-contributory. Routine laboratory tests, hepatitis panel and human immunodeficiency virus tests were normal. Histopathological examination of multiple biopsy specimens showed similar features of hyperkeratosis, papillomatosis and acanthosis with proliferation of basaloid cells containing multiple horn cysts [Figure 3]. There was no dermal infiltrate.

Based on the clinical and histopathological findings, a diagnosis of giant seborrhoeic keratoses was made and the patient was referred to plastic surgery department for further management.

DISCUSSION

SKs are common benign lesions, which usually present with multiple pigmented papules and plaques with a “stuck on” appearance. Lesions are rarely more than 3 cm in diameter and

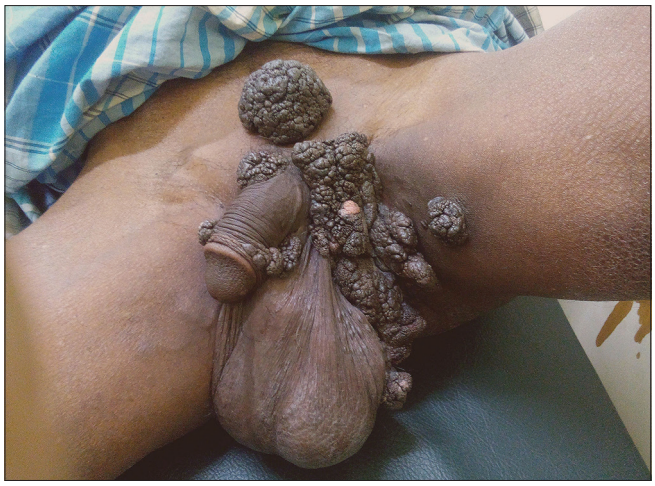

Figure 1: Large, blackish growths with verrucous, lobulated surface over the pubis, penis, scrotum, groin, and upper thigh

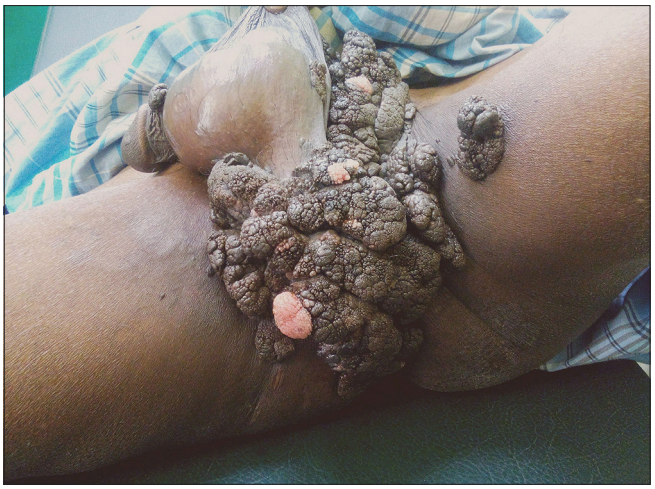

Figure 2: Large, warty, lobulated tumors over the perineum, groin and upper thigh. Some areas are reddish, with eroded surface

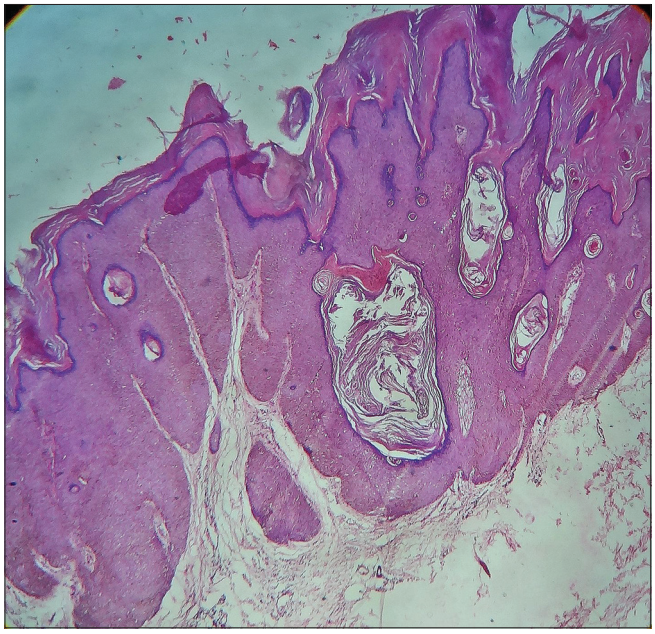

Figure 3: Histopathology showing hyperkeratosis, acanthosis with basaloid cells, papillomatosis and horn cysts within the acanthotic epidermis (H and E, ×100)

occur most often on trunk, face, and extremities, particularly over the sun exposed areas. The lesions tend to increase in number and size with advancing age. Morphologic variants of SK include the common flat type, skin tag like, stucco keratosis, dermatosis papulosa nigra, inverted follicular keratosis, and melanoacanthoma.[1] Large lesions are often pedunculated.

Large, often polypoidal lesions have been reported to occur on the genital/perigenital area on rare occasions. Multiple giant pedunculated lesions over the penis of 20 years duration,[3] perianal polypoidal lesions,[4,5] and large perigenital lesions complicated by myiasis[6] have been reported in the past. Extensive female genital involvement was also reported.[7] There was also a report of giant pedunculated lesion occurring over the groin.[8] However, such extensive involvement as in our case with lesions over the pubic area, genitals, scrotum, perineum, thigh, and perianal areas has not been documented previously.

Giant SK may have to be differentiated from condyloma acuminata,[5] melanoma,[9] and Buschke Löwenstein tumor.[10] Condyloma acuminata or genital warts usually involve the glans and shaft of the penis and the perianal area, but may affect the adjoining skin. The lesions are usually skin colored to brownish, have a rough surface with filiform projections and lack the greasiness of the surface typical of SK. Buschke Löwenstein tumor is a locally aggressive verrucous carcinoma that typically starts on the prepuce and slowly grows into a cauliflower like mass. The lesions may ulcerate and are typically malodorous. Melanomas are darkly pigmented, show irregularity of border and color with frequent ulceration, bleeding and local lymph node involvement.

SK, however, can be easily differentiated by its characteristic histopathologic features. Several histological subtypes are generally recognized: Acanthotic, hyperkeratotic, adenoid (reticulated), clonal, irritated, inverted follicular keratosis, and melanoacanthoma.[11] Of these, the acanthotic subtype is the most common variant. The acanthotic type, as in our case, demonstrates hyperkeratosis, marked acanthosis with basaloid cells, papillomatosis and presence of horn cysts or pseudocysts.[11] The cause of genital SK is as yet unknown, but there may be a possible role of chronic friction.[2] Formation of *in situ* carcinoma and basal cell carcinoma has been documented rarely in acanthotic SK.[11] The common flat type of SK may be left alone or may be treated with liquid nitrogen cryotherapy, curettage, shave excision, or light electrodessication. The large and extensive lesions as in our case, however, need surgical excision and plastic reconstruction.

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Cite this article as: Bandyopadhyay D, Saha A, Mishra V. Giant perigenital seborrheic keratosis. Indian Dermatol Online J 2015;6:39-41.

Source of Support: Nil, **Conflict of Interest:** None declared.