Ind J Dermatol Venereol Leprol 1993; 59 :140-

ACQUIRED HYPERTRICHOSIS LANUGINOSA

Pramod Kumar, Ganesh S Pai, Jerome Pinto, Narendra Kamath

Acquired hypertrichosis lanuginosa developed rapidly in a patient with no detectable malignancy. Soft, fine, downy hair growth was noticed on the face, ears, limbs and trunk. Bilaterally symmetrical vitiliginous macules were present on the ear and preauricular region. This case is reported because of its rarity, absence of any detectable malignancy, and development of vitiligo, which to our knowledge has not been reported earlier.

Key Words : Acquired hypertrichosis lanuginosa, Vitiligo, Malignancy

Introduction

Acquired hypertrichosis lanuginosa[1] is a rare disorder of which only 55 cases have been reported. It is characterized by excessive growth of fine, downy, hypopigmented lanugo-like hair on the face, trunk and limbs. The hair may grow rapidly upto several cm in a few weeks. They may or may not replace hairs which were normally present in the scalp, beard, axillae and pubis. Palms and soles are spared. This condition may be associated with other features[2,3] like glossitis, disturbed taste, diarrhoea, ichthyotic changes, follicular keratosis and pigmentation of the skin and oral mucosa. Some cases with acanthosis nigricans have also occurred. Malignant tumours[2,4] of the GIT, lung, bladder, breast and uterus have been known to precipitate such hair growth; lymphomas and leukaemias are also reported to occur.[1] In most of the cases the malignancy is detectable but in some only postmortem examination confirmed the existence of a carcinoma. Acquire hypertrichosis lanuginosa may precede th diagnosis of a neoplasm by several years. This condition should be differentiate from congenital hypertrichosis lanugino and iatrogenic hypertrichosis.[1,5] Th former presents usually at birth an persists for life, and the latter occurs wit use of drugs such as corticosteroids phenytoin, diazoxide, streptomycin thiacetazone,[6] minoxidil, psoralen an panicillamine, which is reversible o withdrawing the drug.

Case Report

A 38-year-old man develope excessive hair growth with rapid onset o his body of 2 months duration associate with lightening of colour of the existin scalp and body hair. He had lost weigh and experienced severe burning pain i the tongue with altered taste one mont preceding the growth of hair. He was a smoker and an alcoholic. There was n history of ingestion of any medicament prior to the onset of the complaints. History suggestive of photosensitivity wa absent. Family members were no affected. On cutaneous examinatio excessive, downy hair growth was see on his forehead, ears, trunk and limb

From the Department of Skin and STD, Kasturba Medical College, Mangalore - 575 001, India.

Address correspondence to : Dr Pramod Kumar, OP No. 29, Wenlock District Hospital, Mangalore - 575 001

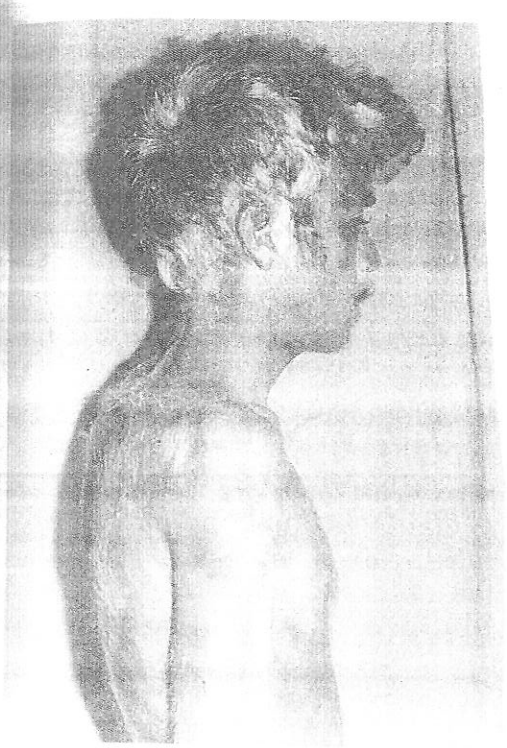

Fig. 1. Downy hair on face, trunk and arm, depigmented macules on ear and preauricular region

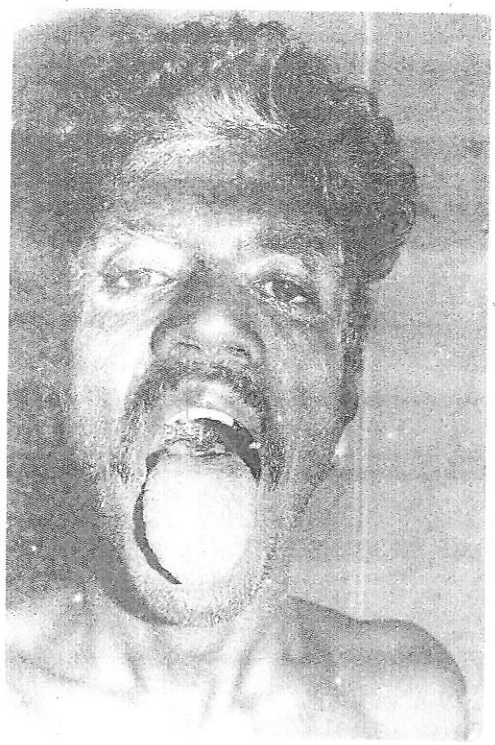

Fig. 2. Fissures on tongue with pigmentation of palate

sparing palms and soles (Fig. 1). The hairs were hypo as well as depigmented and varying from 0.5 cm to 4 cm in length. Hairs on scalp, face, axillae and pubis were hypopigmented. In addition bilaterally symmetrical vitiligo macules were seen over the lobules of the ears and preauricular areas (Fig. 1). These macules had developed along with the presenting complaints. The tongue was erythematous, swollen and bald with multiple fissures. Extensive hyperpigmented macules were present on the oral mucosa (Fig. 2).

His pulse rate, blood pressure were normal and systemic examination did not reveal any findings. Routine blood, urine and stool examinations were normal. ESR was 35 mm at 1 hour. Liver function tests were within normal limits. ELISA for HIV was negative. Chest X-ray was normal, Gastroendoscopy examination was suggestive of oesophagitis, antral gastritis and duodenitis. Ultrasound scanning of abdomen and pelvis did not reveal any abnormal growth. Patient was treated with antacid and discharged on request. Six weeks later the patient reported back to the hospital with hoarseness of voice and cough of sudden onset. ENT examination and bronchoscopy did not reveal any growth. Bronchial lavage cytology did not show any malignant cells. Repeat chest X-ray and barium meal follow through X-ray revealed no tumour. He was administered antibiotics, NSAIDS and antihistamines. Two weeks later his voice improved, cough was reduced. He was discharged and advised to come for further investigations at regular monthly intervals to detect the possible clinical appearance of a malignancy.

Comments

The case mentioned here had rapid onset of excessive hair growth on his face, trunk and limbs a month after he developed burning pain and fissuring of the tongue. When hypertrichosis is associated with oral pigmentation, glossitis, oesophagitis and gastro-duodenal ulceration, it points towards a underlying gastrin producing tumour.[3] An apudoma[7] can also induce hypertrichosis. However, in this patient routine tests, radiological examination, gastroendoscopy and ultrasound scanning did not reveal any underlying malignancy. Some cases of acquired hypertrichosis langinosa may precede the developement of a detectable tumour by several years[1] and probably this case belongs to such a group. However, further regular follow-up will be needed to detect the growth. This case report also highlights the development of bilateral, vitiliginous macules on the ears and preauricular region, appearing with the onset of the presenting complaints.

The association of acquired hypertrichosis lanuginosa and vitiligo has not been reported in earlier reviews.[2,4] We propose to add vitiligo to the list of associated cutaneous features of acquired hypertrichosis lanuginosa.

References

1. Dawber RPR, Ebling FJG, Wojnarowksa F. Disorders of hair. In : Textbook of Dermatology (Champion RH, Burton JL, Ebling FJG, eds), 5th edn. Oxford : Blackwell Scientific, 1992; 2559.
2. Jemec GBE. Hypertrichosis lanuginosa acquisita. Report of a case and review of literature. Arch Dermatol 1986; 122: 805-8.
3. Goodfellow A, Calvert H, Bohn G. Hypertrichosis lanuginosa acquisita. Br J Dermatol 1980; 103 : 431-3.
4. Sindhuphak W, Vibhagool A. Acquired hypetrichosis lanuginosa. Int J Dermatol 1982; 21 : 599-601.
5. Krishnaswamy R, Kumar I, Verma A. Hypertrichosis universalis congenita. Ind J Dermatol Venereol Leprol 1981; 47 : 286-9.
6. Nair VL, Sugathan P. Thiacetazone induced hypertrichosis. Ind J Dermatol Venereol Leprol 1982; 48 : 161-3.
7. Davies RA, Newman DM, Phillips MJ, et al. Acquired hypertrichosis lanuginosa as a sign of internal malignant disease. Canadian Med Assoc J 1978; 118 : 1090-6.

Acknowledgements

The authors are indebted to Dr Anand Kini, Department of Surgery and Dr Naveen Chandra Shetty, Department of Radiodiagnosis, Kasturba Medical College, Mangalore, for their help.