CORNU CUTANEUM GENITALIS.

(A Review and Study of 9 Cases)

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INTRODUCTION.

Cornu cutaneum is a rare form of neoplasm, occurring as a horn like excrescence, greatly varying in size and shape. It may be cylindrical, conical, or straight, tortuous or irregular in shape. The horn may be narrow or elongated to a length of several cm. It is usually single and yellowish brown in colour. Its base is erythematous, discoid and elevated. The lesion grows slowly and becomes medullated.

The cutaneous horn occurs usually in elderly persons but may rarely in the young. It may develop in an area of normal skin but more commonly on a sikn lesion such as scar of trauma or burns, nevus, wart, open sebaceous cyst or senile keratosis. However the pathogenesis is problematic. The horn occurs chiefly on scalp, forehead, nose, ear or hand and occasionally on the glans Penis (C. C. Genitalis) or Scrotum. Epitheliomatous degeneration is likely to occur in many, after some years. In 12 out of 83 cases the cut. horn occurred coincidentally with squamous cell carcinoma or had an epitheliomatous base (MONTGOMERY, D. W., 1941). Thus the lesion is precancerous and so in every case histopathological examination as well as periodical clinical examination at intervals should be invariably done for early detection of malignant changes.

Histopathology. The tumour is primarily epithelial. The horny material is composed of a stratified mass of dense hyperkeratotic *St. Corneum* with irregularly scattered areas of parakeratosis. *St. Mucosum* is also thickened. Marked prolongation of the rate processes deep into the dermis is present. There is perivascular infiltration with lymphocytes and plasma cells. The appearance of the base depends on the original basic lesion. There may be epitheliomatous changes when malignancy supervenes. It must however be remembered that histopathological picture of the normal mucocutaneous junctions such as the glans penis and inner surface of prepuce is different from that of the skin elsewhere.

DIFFERENTIAL DIAGNOSIS.

1) *Sebaceous Horn.* which occurs as one of the complications in a sebaceous cyst. From the duct orifice the contents slowly escape, get deposited in successive layers from below and get dessicated, inspissated and fibrillated. The sebaceous material is composed of fatty, cheesy material, cholesterol, granular debris and epithelial cells.

2) *Localised Keratoses.* such as Epithelial cysts or Keratomas, Nevus Verrucosus etc.

Treatment. The best method is to do wide surgical excision or curettage or destruction by Diathermy if small, followed by fulguration of the base to destroy the underlying tissue.

Material & Method. The statistical data pertain to the 9 patients with penile horns who attended the male Venereal department, Erskine Hospital, MADURAI from 1957 September to 1962 August. The patients were examined clinically. *Biopsy* of the lesion was done in 4 and *biochemical tests* for presence of fats, protein and Keratin in 3 cases. The case records are analysed under different heads such as Age, marital Status, Residence, Occupation, duration of illness, concomitant Venereal diseases etc., and certain conclusions drawn are appended.

DATA AND RESULTS.

1) *Age Distribution.* Ages 17 to 23–2 cases, 24 to 29–2, 30 to 35–2, 36 to 41–1, 42 to 47–1 and above 48–1 case. Minimum Age–18, Maximum Age–52, Average Age–33.6.

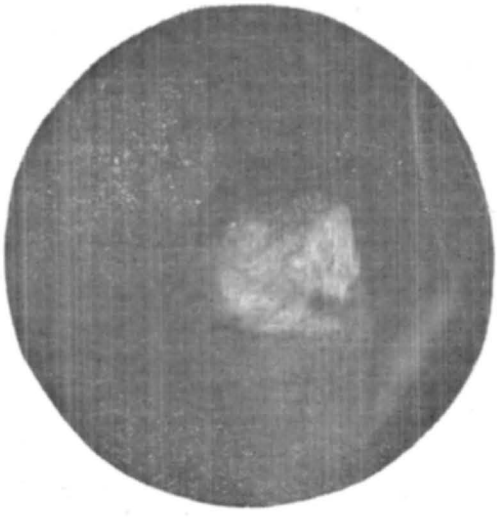
2) *Marital Status.* Single–1; Married–8.

3) Distribution according *to Residence.* Urban–1; Taluks of Madurai District–3; Neighbouring Districts–5.

4) *Occupational Status.* Skilled worker–1; Ryot–2; Police–1; Hotel Servant–1; Shop-keeper–1; Cooly–1; unskilled worker–2.

5) *Duration of illness* varied from 1 month to 3 years.

6) *Associated Venereal Diseases.* 3 had non specific urethritis, 1 had Trichomonal urethritis and 1 had Venereal Granuloma also. Serological Test for syphilis was negative in all.



7) *Site of the Lesion.* In 8 out of 9, the lesions occurred on the Glans Penis especially on its dorsum and the contiguous areas of coronal sulcus (Typified in Figure I–Vide Plate). In one it had extended up to the fraenal site. In the 9th the lesion was on the inner surface of prepuce.

8) *State of Prepuce.* In 3 cases the prepuce was retractable and intact while in the other 6 it had been circumcised. In one of the latter group circumcision had been done years ago, in 4 it had been done recently by quacks who had also applied some crude drugs post operatively and in the last by a qualified doctor. The post operative wounds did not heal but became the seat of keratotic lesions that increased gradually in size and thickness.

9) *Regional Lymph glands.* They were palpable and firm in 4 cases but not inflamed.

10) *Laboratory Examination.* Biochemical examination of the Keratotic material in 3 cases proved it to be protein (Keratin) and not fats.

11) *Bio sy.* Histopathological examination did not reveal any evidence of malignancy. But in one case there was an associated carinomatous lesion (Penile), a little away from the site of the cut. horn.

CONCLUSIONS.

Analysis of the above statistical data and the case records reveals that the disease occurred even in young adults and that mostly in married people the significance of which is not known. There was no greater incidence of the penile horns in any particular section of the community. It is evident that the lesions occurred in 56% cases soon after circumcision. It is therefore surmised that the operative interference and subsequent application of crude drugs might have acted as prediaposing factors and that the association of circumcision with Penile horns may be *causal* rather than casual. In 11% there was associated Penile cancer.

ACKNOWLEDGMENT

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