LESER-TRELAT SIGN

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An elderly male developed multiple, pruritic seborrhoeic keratoses over the trunk and face along with the signs and symptoms of carcinoma of the rectum. After surgical removal of the tumour, the skin lesions showed evidence of regression. Sudden development of pruritic seborrhoeic keratoses in association with an internal malignancy indicated Leser-Trelat sign.

Key words : Seborrhoeic keratosis, Leser-Trelat sign, Carcinoma rectum.

Many cutaneous lesions have been described as markers of internal malignancy. The recognition of these skin lesions constitutes a diagnostic challenge in the field of dermatology. Leser-Trelat sign is defined as the sudden appearance of, or a rapid increase in the number and size of seborrhoeic keratoses, sometimes accompanied by pruritus.[1] It is usually associated with adeno-carcinoma of the gastro-intestinal tract. It has also been reported in association with lymphomas and leukemias and malignancies affecting various organs like uterus, ovary, lungs, breast and prostate.[2-7] In most cases, the malignancy and the skin lesions appear simultaneously,[2,4,8] though rarely the skin lesions may precede the discovery of the malignancy.[5,7] We report a case in which multiple, pruritic, seborrhoeic keratoses erupted simultaneously with the signs and symptoms of carcinoma of the rectum.

Case Report

A 54-year-old male was seen for backache, increasing constipation with a feeling of incomplete defaecation and recurrent bleeding per rectum since 6 months. Along with these symptoms he developed multiple, pruritic, brownish-black papules and plaques on the trunk and face (Fig. 1). These skin lesions were well-defined and varied from 3 to 15 mm in diameter. The surface was verrucous and had a soft friable consistency. A hard, irregular, intra-abdominal mass was felt in the left iliac fossa. There was no hepato-splenomegaly or free fluid in the peritoneal cavity. The testes and epididymes were normal. Per rectal examination revealed diffuse, stony hard induration with areas of softening in the lower part of the rectum. The prostate was felt hard and irregular. When the finger was withdrawn after per rectal examination, it was found smeared with blood and mucous.

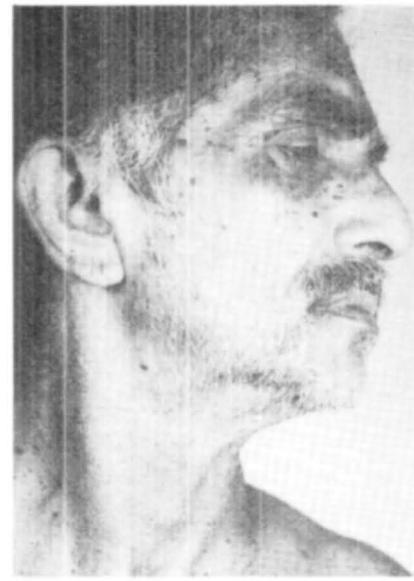

Fig. 1. Leser-Trelat sign. Note numerous seborrhoeic keratoses over the face and neck.

Routine laboratory tests on blood and urine were normal except for low haemoglobin (10 gm%) and raised ESR (54 mm). Stools showed presence of blood. There were no

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amoebae in it. Skiagrams of the chest and spine were normal. Histopathclogical study of the skin lesion revealed hyperkeratosis, acanthosis and papillomatosis. Interspersed within the epidermal cell masses were horn cysts and pseudohorn cysts. Proctoscopy revealed a tumour mass in the lower rectum. Histopathological study of the rectal biopsy revealed features of highly anaplastic, poorly differentiated adenocarcinoma of the rectum. On laparotomy, the rectal growth was found infiltrating posteriorly into the sacral bed and anteriorly into the prostatic bed. The lymph nodes along the superior rectal vessels were enlarged and firm to hard in consistency. A combined synchronous abdomino-perineal excision of the lower rectum was done under general anaesthesia. Permanent colostomy was performed in the left iliac region. The post-operative period was uneventful. Three months after the operation, the skin lesions showed evidence of regression and remained asymptomatic.

Comments

Seborrhoeic keratosis is not an uncommon disorder in elderly individuals. But the sudden development of numerous lesions, their pruritic nature and rapid progression simultaneously with the progression of the malignancy of the rectum in our patient suggested that their association was more than fortutious. After surgical removal of the tumour mass, the skin lesions regressed partially. When originally described, pruritus was not a component of Leser-Trelat sign. In 1965, Ronchese included freckles and severe pruritus in addition to the seborrhoeic keratoses, as a part of the Leser-Trelat sign.[9] Our patient had severe pruritus associated with the skin lesions and it was relieved after removal of the tumour. The exact aetiopathogenesis of Leser-Trelat sign is not well understood. A breakdown in the defence mechanism of the host, permitting the simultaneous proliferation of the tumour and development of the cutaneous lesions has been suggested.[1] More important for the physician is to be aware of this sign so that the underlying malignancy can be detected and treated early.

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