INDIAN J DERMATOL VENEREOL LEPROL 1988; 54 : 262-263

MULTIPLE KERATOACANTHOMAS ON THE MONS PUBIS AND LABIA MAJORA

K Pavithran

An elderly woman developed multiple keratoacanthomas on the mons pubis and labia majora. Some lesions coalesced to form large irregular plaques with multiple craters. Biopsy of a well-developed nodule revealed keratin-filled craters, pseudoepitheliomatous hyperplasia with horn pearls and dyskeratosis of prickle cells which appeared eosinophilic and glassy. Though a few lesions involuted spontaneously, some persisted. These responded well to topical 5-fluorouracil therapy. There was no recurrence of lesions, on long follow-up.

Key words : Keratoacanthoma, Labia majora, 5-Fluorouracil.

Keratoacanthoma is a benign, self-healing tumour of the skin characterized by the development of dome-shaped hemispherical nodules with central keratin-plugged craters. It may simulate squamous cell carcinoma, both clinically and histopathologically. It is only rarely seen in dark-skinned races, though it is common in white races. Clinically, three types of keratoacanthomas are recognized : solitary, multiple and eruptive.[1] Solitary type is the commonest type and it develops usually on the face, arms and back of hands. Multiple keratoacanthomas are frequently referred to as Ferguson-Smith type of multiple self-healing squamous epithelioma. It is a rare type and the sites commonly affected are the face, trunk and genitalia. These may occur in any number but generally only 3 to 10 lesions have been noted. We report a case of multiple keratoacanthomata localized to the external genitalia in an elderly woman.

Case Report

A 54-year-old woman developed multiple, mildly pruritic cutaneous nodules on the external genitalia since 8 months. She denied history of preceding local trauma. Each lesion started as a papule that enlarged rapidly for 4 to 6 weeks to attain the full size after which some of the nodules involuted spontaneously within 3 to 4 months, leaving depressed scars. The lesions were multiple, firm, non-tender, skin-coloured, well circumscribed, hemispheric, dome-shaped nodules, 0.5 to 3 cm in size on the pubic region and labia majora (Fig. 1). Each nodule showed a central crater filled with firmly embedded keratinous plug. Some nodules coalesced

Fig. 1. Multiple keratoacanthomas on the mons pubis and labia majora. Note large plaques with multiple keratin-filled craters, formed by coalescence of a few nodules of keratoacanthomas.

From the Department of Dermatology and Venereology, Medical College Hospital, Kottayam- 686 008, India.

to form irregular, raised plaques with multiple craters. There was no induration of the base or fixity to the underlying structures. There was no significant enlargement of the inguinal lymph nodes. Per rectal, per vaginal and proctoscopic examinations did not reveal any abnormality. Other systems were clinically normal.

Routine laboratory tests on blood, urine and stools were normal. Blood VDRL was negative. Skiagram of the chest did not show any abnormality. Biopsy of one of the well-developed nodules showed hyperkeratosis, keratin-filled crater and lip-like extension of the epidermis over the sides of the crater. There were irregular proliferations of epidermal cells downwards with pseudoepitheliomatous hyperplasia. The prickle cells in some areas showed dyskeratosis and appeared eosinophilic and glassy. There were many horn pearls also. Dense inflammatory cell infiltration was seen in the dermis.

The patient was followed up periodically and watched for evidence of spontaneous regression of the nodules. Only 40% of the nodules regressed by the end of 9 months. So an ointment containing 5-fluorouracil was applied over the remaining lesions twice daily. There was 70% reduction in the size of the nodules at the end of 3 weeks and all the lesions regressed with insignificant scarring at the end of 6 weeks. There was no recurrence of the lesions when followed up for 6 months.

Comments

Though a few cases of keratoacanthomas have been reported from India,[2,3] it is an extremely rare disease seen in this part of the country. Morphology of the skin lesions with characteristic keratin-filled craters, their rapid growth to attain full size and spontaneous involution of a few lesions after remaining stationary for some time, suggested a clinical diagnosis of keratoacanthoma in our patient. Histopathological features further strengthened this diagnosis. Multiplicity of the lesions, lack of induration of the base or fixity to the underlying structures, absence of regional lymphadenopathy and occurrence of spontaneous regression of some nodules excluded the possibility of squamous cell carcinoma. Though keratoacanthoma may rarely develop at unusual sites like lip, subungual region and interdigital space,[3-6] strict localization of the lesions on the mons pubis and labia majora as observed in our patient, is quite uncommon. Unlike the other types, multiple keratoacanthomata have an unpredictable course and are resistant to treatment. Various treatment modalities tried in keratoacanthomas include surgical excision, fulguration, topical bleomycin, oral methotrexate and intralesional corticosteroid. Goette et al[7] observed topical 5-fluorouracil to be very effective in the treatment of keratoacanthomas. The lesions in our patient also responded dramatically to topical 5-fluorouracil therapy and there was no recurrence.

References

1. Baer RL and Kopf AW : Keratoacanthoma, in : Year Book of Dermatology, Editors, Baer RL and Kopf AW : Year Book Medical Publishers, Chicago, 1962-1963; p 7-42.
2. Mehta VR : Keratoacanthoma with osteolysis (a case report with an isolated interdigital lesion), Ind J Dermatol Venereol Leprol, 1980; 46 : 360-363.
3. Subramanyam CSV, Verma RN and Saikia DK : Multiple keratoacanthoma, Ind J Dermatol Venereol Leprol, 1983; 49 : 275-277.
4. Kohn MW and Eversole LR : Keratoacanthoma of the lower lip, J Oral Surg, 1972; 30 : 522-526.
5. Silberberg I, Kopf AW and Baer RL: Recurrent keratoacanthoma of the lip, Arch Dermatol, 1962; 86 : 44-53.
6. Lamp JC, Graham JH, Urbach F et al : Keratoacanthoma of the subungual region : A clinicopathological and therapeutic study, J Bone Joint Surg, 1964; 46 : 1721-1731.
7. Goette DK, Odom RB, Arott JW et al : Treatment of keratoacanthoma with topical application of fluorouracil, Arch Dermatol, 1982; 118 : 309-311.