CONFLUENT AND RETICULATE PAPILLOMATOSIS
A case report

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Summary

A rare skin disorder - Confluent and Reticulate Papillomatosis - is described in a 26 years old male. There was no evidence for the presence of pityrosporum orbiculare in the skin lesions Twelve percent urea cream was found to be very effective.

KEY WORDS : Papillomatosis - Confluent and reticulate, Cutaneous Papillomatosis.

Confluent and reticulate papillomatosis (CRP) was first described by Gougerot and Carteaud in 1927 under the name Papillomatose pigmentee innominee[1,2]. It is a very rare disorder and only about 50 cases have been reported in literature[3]. It is predominently seen in females and usually starts after puberty. The exact aetiology of this disorder is unknown. Some regard it as a genetically determined defect of keratinization[4]. Familial occurrence has been noted rarely[5]. The most recent view on the etiology is that it is an abnormal host response to the colonization by pityrosporum orbiculare[6]. Waisman believes that it is the same disease as pseudoacanthosis nigricans, and occurs primarily in obese persons[7].

Clinically[8, 9, 10] individual lesions are flat-topped or dome shaped warty papules. The neighbouring papules become confluent in the centre of the affected area but only partially so at their periphery, to form an irregular network. These first appear in the inter-mammary area and in the midline of the back and then extend up and down on the trunk. Face alone may be affected in some cases ([3]). The lesions are usually asymptomatic. The mucosa is never affected and systemic symptoms are absent. Histology reveals hyperkeratosis and papillomatosis. Epidermis is acanthotic with some areas of atrophy[11]. Treatment is largely ineffective. Temporary or partial resolution of the lesions have been reported with vitamin A, steroids, U.V.L. and topical keratolytics[12].

Here we report a case of CRP in a young man.

Case Report

A 26 years old man attended the Dermatology Department at Medical College Hospital, Trivandrum complaining of asymptomatic brownish black lesions on his trunk. These started on the presternal area at the age of 18 years and thereafter gradually spread to the front and back of the trunk, sides of the neck and shoulders. There was no history of similar disease in his family. The lesions con-

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sisted of multiple bilateral brownish black plaques. Each plaque was surrounded by discrete, flat topped brownish black and slightly verrucous papules, to form an irregular network, (Fig. 1 & 2). The lesions were more prominent on the back than on the front of the chest. When scratched a mealy scale was detached which crumbled under the finger nails. There were no lesions on the face, limbs or genitalia. Mucous membranes were not involved and systemic signs were absent. The hairs and nails appeared normal.

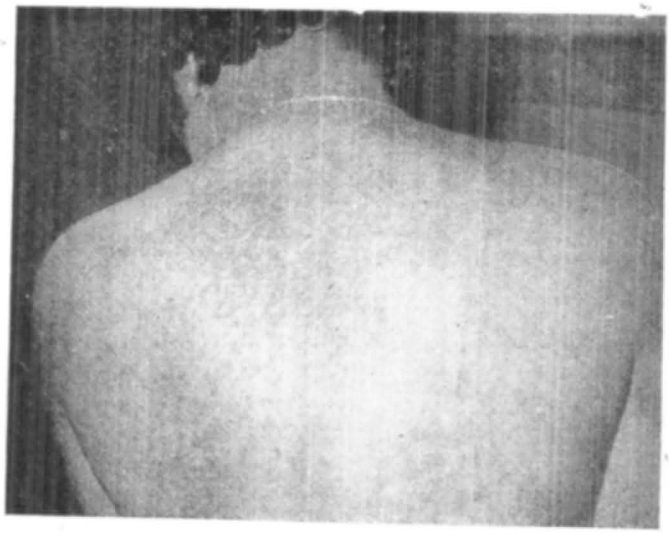

Fig. 1

Confluent and Reticulate papillomatosis. Back view of the patient.

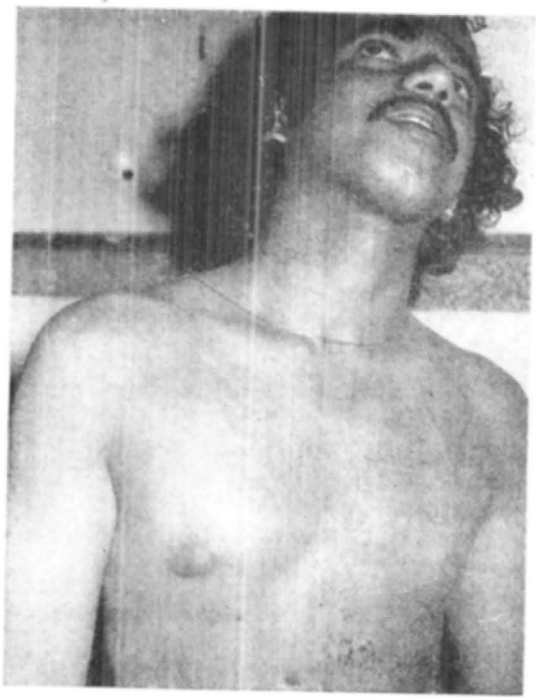

Fig. 2

Front view of the patient of Fig 1. Note the localisation of lesions mainly on the presternal area and neck.

Investigations

Routine examination of the blood for Hb, TC, DC, ESR, VDRL, and Urine did not reveal any abnormality. Skin scrapings taken from lesions at different sites and examination in 10% KOH did not reveal any spore or mycelium.

Histology of the skin lesion revealed hyperkeratosis, irregular acanthosis alternating with areas of atrophy of Malpighian layer and papillomatosis. Upper dermis showed scanty mononuclear cell infiltration around the blood vessels (Fig. 3). PAS staining did not show any spore or mycelium in the horny layer.

Discussion

Confluent and reticulate papillomatosis is a rare disorder encountered in dermatological practice. Only 50 cases have been so far recorded in the literature[3]. The age of onset, the morphology, distribution and histology of the lesions are all in favour of a diagnosis of CRP in our patient. The disease is common in females. The aetiopathogenesis of this rare disorder is still not clear, though there are different views on this. Though familial cases have been reported[5], most cases are sporadic. Our patient did not have a family history of a similar skin disorder. Some believe that CRP is the same disease as pseudoacanthosis

Fig. 3

Histology of a case of CRP. Note hyperkeratosis, acanthosis and papillomatosis (10 x 5)

Treatment given

Partial remission of the skin lesions was noted on application of 3% salicylic acid skin ointment. But the response was only temporary and the lesions recurred on discontinuing the ointment. Application of 1% clotrimazole (IMIDIL-LYKA) did not give any response. Response to the external application of 12 percent urea cream (COTARYL-FDC) was more long lasting than that with salicylic acid ointment.

nigricans primarily occurring in the obese[7]. Histological changes are similar in both CRP and acanthosis nigricans[13]. The weight (54 Kg.) of our patient was only in proportion to his height and age. The characteristic velvety nature of the lesions of acanthosis nigricans was not observed in our patient.

Recent view is that CRP is the result of abnormal host response to colonization by pityrosporum orbiculare[5]. Examination of the scrapings taken

from the lesions in KOH and PAS staining of the histological sections did not reveal any yeast or mycelium. Further, the application of clotrimazole, an antifungal agent, did not cause any change in the lesions, though urea cream, a keratolytic, caused long lasting remission of the lesions.

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