SELF ASSESSMENT PROGRAMME

A 60 year old businessman presented with a 30-year history of asymptomatic red scaly lesions on the trunk and hyperkeratotic lesions on the palms and the soles. The lesions were unremitting and were not associated with any constitutional symptoms. Physical examination revealed a well built anaemic individual with irregular psoriasiform lesions on the front and back of the trunk. Some of the lesions showed central atrophy. The palms and the soles showed pale yellow discrete papules and large hyperkeratotic plaques. The nails were normal and so were the joints. The nerves were not thickened. The sensations were normal. Auspitz sign was doubtful. Systemic examination was normal.

Which of the following diagnoses is likely ?

1. Psoriasis
2. Dimorphous (borderline) leprosy
3. Secondary syphilis
4. Bowen's disease
5. Arsenical hyperkeratoses.

Which of the following investigations will help ?

1. Skin biopsy
2. S. T. S.
3. Skin slit and smear for AFB
4. Estimation of Arsenic in the hair and the nails.

The biopsy showed hyperkeratosis irregular acanthosis with dyskeratotic cells in the Malpighian cell layer. The STS were negative and so was the skin slit and smear for AFB as well as examination of hairs of Arenic. (As)

Which of the following diagnoses will now become likely ?

1. Bowen's disease.
2. Darier's disease
3. Senile keratoses.

What further investigations would be of help ?

1. X-ray of the chest
2. Ba studies of GI Tract
3. Lymphonode biopsy
4. Sputum examination

X-ray of the chest revealed a large opacity in the Rt. apex. The other investigations were normal. Sputum examination revealed presence of a fragment shed off from a poorly differentiated adenocarcinoma.

What form of treatment should be given ?

1. Anti-mitotic chemotherapy
2. Local excision of the lesions
3. Radiotherapy.

ANSWERS

1. The possibility of the lesions being dimorphous (borderline) leprosy was unlikely in view of sensations being normal and the nerves not being thickened, though posriasiform lesions are well known to occur in dimorphous (borderline) leprosy. Because of the duration of the disease, secondary syphilis could not be considered possible. Presence of atrophy would make psoriasis an unlikely possibility. Bowen's disease/arsenical keratoses was therefore entertained.

2. The histopathology of Bowen's disease/arsenical keratoses is fairly characteristic, with irregular acanthosis and large dyskeratotic cells. Estimation of As would have helped in pinpointing the aetiology of these lesions.

3. Presence of dyskeratotic cells could be seen in Darier's disease as well as in the Bowen's : the absence of intra-epidermal cleavage will exclude Darier's. Senile keratoses though having a lot of acanthosis are seldom associated with dyskeratotic cells.

4. Once a diagnosis of Bowen's disease is made, it is imperative that a thorough search be made for any evidence of systemic malignancy.

The X-ray chest, while negative in the first instance, did reveal the presence of an opacity which on cytopathology was proven to be of a malignant character.

5. In view of the fact that the patient had a number of premalignant (Bowen's) lesions and a systemic malignancy chemotherapy was considered the best choice. The patient improved to an extent but was lost to follow up. The prognosis was in any case grave.

Comment :

Bowen's disease, not an uncommon condition in the whites is relatively uncommon in the coloured population[1]. It seems there has been only one report from this country[2]. It is important to find out whether the disease is really as uncommon as reported or some of the patients are missed under various mistaken diagnoses such as psoriasis, seborhoeic or senile keratoses. It is also of course, entirely possible that the disease is genuinely uncommon.

Once a diagnosis of Bowen's disease is made, one should look for the presence of a systemic malignancy since it is, by now, well recognised that Bowen's disease is not only a premalignant condition but is also a skin marker of systemic malignancy[3]. I think the dermatologists and physicians should be on the lookout for lesions simulating Bowen's disease and subject them to histological examination in case of doubt.

It is difficult to differentiate Arsenical keratoses from Bowen's disease; infact Arsenic is supposed to be the most important aetiological agent in the causation of Bowen's Disease. The practice of dispensing Fowler's solution or As in indigenous preparations should be discouraged.

Referenes :

1. Graham JH and Helwig EB : Bowen's disease and its relationship to systemic cancer. Arch Derm, 83 : 738, 1961.

2. Jalihali SV and Bhatt PA : Bowen's disease. Ind. J Derm & Vener, 28 : 33, 1962.

3. Graham JH and Helwig EB : Bowen's disease and its relationship to systemic cancer. Arch Derm, 80 : 133, 1959.

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Association News and Notes

INDIAN ASSOCIATION OF DERMATOLOGISTS, VENEREOLOGISTS & LEPROLOGISTS

Andhra Pradesh Branch

The first meeting of I. A. D. V. & L. A. P. Branch was held at the Department of Dermatology, Osmania General Hospital, Hyderabad on 25—1—1978. Dr. P. Ramana Rao, Professor and Head of the Department of Dermatology, Osmania Medical College assisted by his colleagues made necessary arrangements for this meeting.

Dr. G. Narsing Rao, Principal, Osmania Medical College and Dean of Faculty of Medicine presided over the meeting and conducted the proceedings.

Dr. Johan Landegren, Dermatologist, Karolinska Hospital, Stockholm and a member of the editorial board of the popular journal "Acta dermatologica scandinavia" was the chief guest. A galaxy of interesting, common as well as rare skin disorders were demonstrated during the clinical session. Dr. John Landegren delivered an interesting lecture on 'Common dermatological problems in Scandinavia with particular emphasis on skin tumours, infections and eczemas in comparison with those occurring in India.
