

Seborrhoeic keratosis: bilaterally symmetrical linear verrucous lesions in inguinal folds, an unusual presentation

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Abstract Seborrhoeic keratosis is the commonest benign epithelial tumour that occurs from middle age onwards most commonly on sun-exposed areas. We, herewith, report a case of seborrhoeic keratosis with bilaterally symmetrical linear verrucous lesions in both inguinal folds. Linear verrucous epidermal nevus, condyloma acuminata and bowenoid papulosis were excluded by history and histopathological data. Chronic candidiasis of groin in this diabetic patient may be responsible for peculiar localization of the tumour.

Key words

Seborrhoeic keratosis, linear, symmetrical, candidiasis.

Introduction

Seborrhoeic keratosis is the commonest benign skin tumour.¹ Most people will develop at least one such lesion in their lifetime. They primarily affect people older than 30. The lesions can appear on any part of the body except mucous membrane.² However, they are most frequent on the face and upper trunk.³ We are presenting such ubiquitous epithelial tumour because of its unusual presentation and the diagnostic dilemma it posed to us.

Case report

A 41-year-old Muslim male patient from Bangladesh, married and father of two children,

came to our OPD with asymptomatic, pigmented, raised linear lesions in both groins. These started on right groin one and half years ago as a small black mass that gradually grew in length as well as thickness. A similar lesion appeared on the left groin 8 months ago.

On examination, there were pigmented, dry, linear verrucous lesions overlying both the inguinal folds, measuring 10 cm in length on the right and 5.5 cm in length on the left side (**Figure 1**). Those were firm and non-tender on palpation. Around the lesions, the skin was glazed, moist and erythematous, scraping from which showed clusters of yeasts and pseudomycelia diagnostic of candidiasis which was remitting and exacerbating on the same areas for last four years. Rest of the body, mucosae, teeth, hair and nails were normal. The patient had normal hemogram. His fasting blood sugar level was 142 mg/dl. Other biochemical parameters were normal. The patient strongly denied history of illicit exposure. Blood report of VDRL and HIV testing was found to be

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Figure 1 Symmetrical linear verrucous lesions on both inguinal folds with candidiasis of groins and upper medial aspects of thighs.

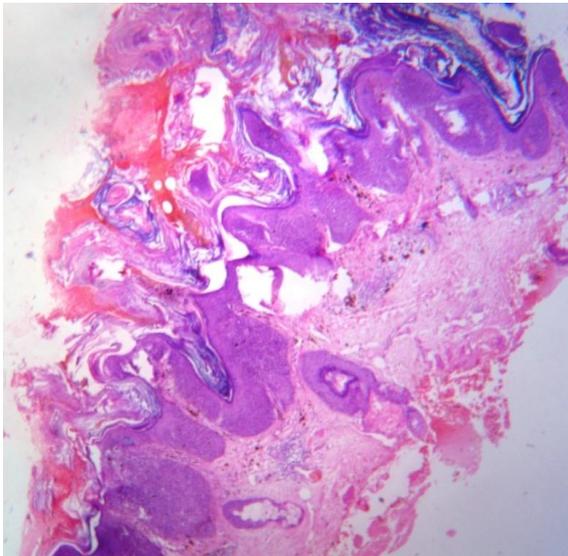


Figure 2 Photomicrograph showing hyperkeratosis, acanthosis and papillomatosis (H&E, x 400), epidermal changes mostly above an imaginary straight line passing through dermis.

negative. He had no suggestive past or family history. He was on oral antidiabetic for last 2 years.

Histological examination of skin biopsy specimen (H&E stain) revealed marked hyperkeratosis with occasional focal parakeratosis, irregular acanthosis, and papillomatosis with a few individual dyskeratotic cells (**Figure 2**). Most of the lesion was situated above the level of the normal

epidermis seen at both ends of the lesion. The upper dermis had chronic inflammatory infiltrate. PAS stain of the section showed no fungal element.

Discussion

On the first visit we thought of the following differential diagnoses. Linearity of the lesions and verrucous appearance suggested verrucous epidermal nevus, though the age of onset and bilateral yet localized distribution spoke against it. Location of the disease made us to think of condyloma acuminata and bowenoid papulosis. But genital region was free of lesion. The patient and his wife had no history or evidence of STD. More importantly, histological examination revealed no koilocyte or evidence of cellular dysplasia, thereby excluding viral wart or any premalignant condition. In fact it is the histological observation of a benign looking epidermal proliferation that prompted us to the diagnosis of seborrhoeic keratosis. More precisely, it conformed to the hyperkeratotic variety of seborrhoeic keratosis.

Seborrhoeic keratosis has no predilection of sex and is somewhat less common in black races than in the white. Although no specific etiological factor has been identified, they occur more frequently on sun-exposed areas. Multiple seborrhoeic keratoses may be a familial trait, with an autosomal dominant mode of inheritance.⁴ Epidermal growth factors are implicated in the development of seborrhoeic keratoses.⁵ The eruptive appearance of multiple seborrhoeic keratoses in association with various internal malignancies and with concomitant acanthosis nigricans suggests the possibility that a tumour-derived circulating growth factor or humoral factor may be involved in its pathogenesis.² An eruption of seborrhoeic keratosis may be precipitated by inflammatory

dermatosis.⁶ Can chronic candidiasis, in our case, be responsible for the peculiar localization of seborrhoeic keratosis?

Clinical variants of seborrhoeic keratosis include dermatosis papulosa nigra, stucco keratosis and melanoacanthoma. We did not come across any report of seborrhoeic keratosis presenting as bilaterally symmetrical linear verrucous lesions on inguinal folds.

The patient was prescribed topical as well as oral antifungal and asked to come for electrodesiccation. We are reporting such a common skin tumour for its most bizarre way of clinical presentation.

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