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Original Research Paper

Dermatology

A CASE REPORT ON RARE ATROPHIC VARIANT OF DERMATOFIBROMA

Ruttala Sri Satya	Post Graduates Dept. Of DVL, KIMS, Amalapuram.
Areti Sri Laxmi*	Post Graduates Dept. Of DVL, KIMS, Amalapuram. *Corresponding Author
Sappa Ramatulasi	Associate Professor, Dept. Of DVL, KIMS, Amalapuram.

ABSTRACT

BACKGROUND: Dermatofibroma is a benign fibrohistiocytic tumor of unknown origin and has varied clinical and histological presentations. Atrophic dermatofibroma is a rare variant characterised by flat and depressible surface and is often misdiagnosed.

CASE CHARACTERISTICS: A 52year old woman presented with dark depressed plaques with raised edges over right shoulder, left upper arm and right breast. Histopathological examination correlates with diagnosis of atrophic dermatofibroma.

CONCLUSION: We report this case to highlight the occurrence of atrophic variant of dermatofibromas multiple in number and also because of their large size.

KEYWORDS :

INTRODUCTION:

Dermatofibroma is a benign tumour of fibrohistiocytic origin [1] that is seen in mid adult life and shows a slight female preponderance. Atrophic dermatofibroma is a rare variant characterised by flat and depressible surface and is often misdiagnosed.

CASE REPORT:

A 52 year old woman presented with dark coloured lesions over right shoulder, left upper arm and right breast since 4years. Similar lesions developed over medial aspect of left breast since 1year. Complains of mild pruritis since 3 months. No prior history of trauma or intralesional injections. Started as small firm elevated lesions & gradually progressed to depressed lesions of present size. On examination atrophic plaques of size varying from 6-18cm interspersed with raised linear plaques are present over the above areas (figure1 and 2). Morphea, keloid, Atrophoderma were considered in the differential diagnosis.

Punch biopsy from the plaque over right shoulder revealed (figure 3) epidermis with mild hyperkeratosis, acanthosis, mild underlying of rete pegs & slight increase in the basal cell pigmentation. Dermis showed a circumscribed lesion made up of mostly collagen bundles with sparsely distributed spindle cells and entrapped adnexal structures. There is mild periadnexal& perivascular lymphocytic infiltration.

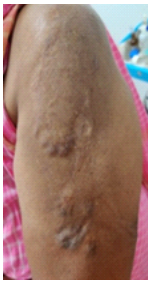

Figure 1

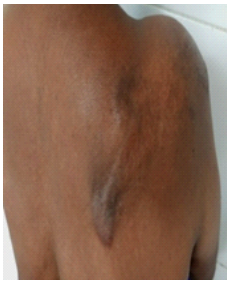

Figure 2

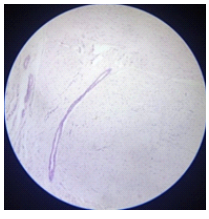

Figure 3

DISCUSSION:

Dermatofibroma is a benign fibrohistiocytic tumour of unkn own origin [1] with varied clinical & histological pres entations.Typical dermatofibromas presents as single or multi ple,firm, reddish-brown nodule or plaque. [2] Apart from classical type, cellular, aneurysmal, giant (>5cm), atrop hic,atypical polypoid variants are present.Atrophic variantfi rst described by Page and Assaad [3] in 1987 is a rare variant of dermatofibroma represents approximately 2% of all derma tofibromas [4] and tends to occur on the uppertrunk & upper extremities of middle aged women [2]. The lesion may be misd iagnosed as morphea, atrophoderma, localised lipoatrophy, resolving panniculitis, steroid atrophy, basal cell carcinoma, anetoderma or nevus [5] while histology shows classic features of dermatofibroma.

CONCLUSION:

We report this case to highlight the occurrence of atrophic variant of Dermatofibroma, multiple in number and also because of their large size.As it is often misdiagnosed, the clinician and pathologist should consider this diagnosis in evaluation of atrophic lesions.

REFERENCES:

1. Philip R. Cohen, Christ of P. Erickson & AntoanellaCalame Atrophic Dermatofibroma: A Comprehensive Literature Review. DermatolTher 2019; 9:449–468.
2. Bandyopadhyay MR, Besra M, Dutta S, Sarkar S. Dermatofibroma: Atypical presentations. Indian J Dermatol 2016; 61:121.
3. Page EH, Assaad DM. Atrophic dermatofibroma and dermatofibrosarcom a protuberans. J Am AcadDermatol1987; 17:947-50
4. Mota ANCM, Tortelly VD, Obadia DL, Silva RSAn Bras Dermatol. 2013; 88(5):793-5.
5. A. Hendi, MD, D. M. Jukic, MD, D. W. Kress, MD, AND D. G. Brodland, MD De rmatolSurg 2002;28:1085–1087