

MULTIPLE GIANT CORNUAE CUTANEUM AN UNCOMMON PRESENTATION OF A NOT SO UNCOMMON CONDITION

Kashetty Srujan Kumar

Post Graduates Dept. Of DVL, KIMS, Amalapuram.

Thotla Kavya*

Post Graduates Dept. Of DVL, KIMS, Amalapuram. *Corresponding Author

Sappa Ramatulasi

Associate Professor, Dept. Of DVL, KIMS, Amalapuram.

ABSTRACT

A 93-year-old female presented with a multiple giant cornuae cutaneum over the scalp region. Histopathology showed underlying seborrhic keratosis. Cutaneous horn has been noticed on top of many clinical conditions of diverse etiology, such as actinic keratoses, wart, molluscum contagiosum, seborrhic keratoses, keratoacanthoma, basal cell and squamous cell carcinoma. We report a patient with multiple giant cutaneous horn on the scalp which is proved benign.

KEYWORDS :

INTRODUCTION

Cutaneous horns are conical projections of cornified material [1] above the skin surface ranging in size from few millimetres to several centimeters they develop on many clinical conditions benign, premalignant and malignant. They are of different sizes and shapes and can have satellite lesions. The distribution is usually on sun exposed areas [2]. As they are suggestive of underlying anaplasia ,histological examination is warranted.

CASE REPORT

A 93 year old woman presented with multiple asymptomatic, hyperpigmented lesions over the extremities for the past one year. She gave history of similar lesions developing over her scalp 25 years ago which gradually turned into horny projections. There is no history of pain or bleeding from the lesions.



Figure 1

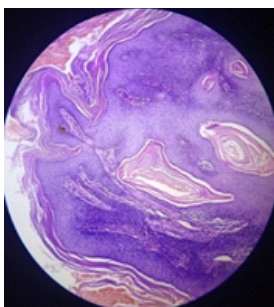


Figure 2

On examination, multiple horny growths measuring 5 to 8cm arranged in groups of 12 to 15 in a flower like pattern were present over the vertex of scalp overlying a verrucous plaque of 10X8 cm Size (figure 1). There is no tenderness or discharge from the lesion or local lymphadenopathy Multiple hyperpigmented macules,flat plaques are present all over the body predominantly over extremities, sun exposed areas of

the trunk.

An incisional biopsy from the base of one of the horns showed hyperkeratosis,marked acanthosis and multiple horn cysts suggestive of seborrhic keratosis (figure 2). There were no signs of malignancy. In view of the wider area of involvement, advanced age, benign nature of the lesion, excision was not done.

DISCUSSION

Cutaneous horns are conical projections of cornified material [1]above the skin surface ranging in size from few millimetres to several centimeters The base of the horn may be flat, nodular or [2]crateriform. The horn is composed of compacted keratin. The distribution of cutaneous horns usually is in sun-exposed areas, particularly the face, pinna, nose, forearms and dorsal hands. Usually, a cutaneous horn is several millimeters long. As of today, there is no precise clinical information to make a distinction of benign or malignant etiology for a cutaneous horn[3].

Most cutaneous horns arise from actinic keratoses[6] but they may also result from seborrhic keratoses, warts, keratoacanthomas, squamous cell carcinomas and basal cell carcinomas. Histologically, in our case from the base of one of the horns showed hyperkeratosis, marked acanthosis and multiple horn cysts suggestive of seborrhic keratosis . The horn at the base will display features characteristic of the pathologic[7] process responsible for the development of the horn.

It is important to know the primary pathology which has led to the cutaneous horn to rule out malignancy and to direct prospective further therapy. Excision biopsy of the lesion and histopathological examination to rule out malignancy is recommended. Clinical pointers toward malignancy are large base or height to base ratio, tenderness, and advanced age. They are usually larger and harder at their base due to inflammation and are present at unusual sites. Malignancies should be excised with appropriate margins[4] and evaluated for metastasis. A careful physical examination of the lymph nodes draining the area of lesion. Inflammation and induration beneath the horn is suggestive[5] of malignant transformation. Malignancy is present in 16-20% of cases, with squamous cell carcinoma being the most common type.

CONCLUSION

This case was reported in view of the large size and unique appearance. It is important to know the primary pathology which has led to the cutaneous horn to rule out malignancy

and to direct prospective therapy. In our case, despite the large size, elderly age, the lesion was proved to be benign on histological examination.

REFERENCES

1. Nath AK, Thappa DM. Crab-like appearance of cutaneous horns. *Indian J Dermatol Venereol Leprol* 2009;75:300-1
2. Kumaresan M, Kumar P, Pai MV. Giant cutaneous horn. *Indian J Dermatol* 2008;53:199-200
3. Gould JW, Brodell RT. Giant cutaneous horn associated with verruca vulgaris. *Cutis* 1999;64:111-2.
4. Solivan GA, Smith KJ, James WD. Cutaneous horn of the penis: Its association with squamous cell carcinoma and HPV -16 infections. *J Am Acad Dermatol* 1990;23:969-72
5. Mencia-Gutierrez E, Gutierrez-Diaz E, Redondo-Marcos I, Ricoy JR, Garcia-Torre JP. Cutaneous horns of the eyelid: A clinicopathological study of 48 cases. *J Cutan Pathol* 2004;31:539-43.
6. Lowe FC, McCullough AR. Cutaneous horns of the penis: An approach to management: Case report and review of literature. *J Am Acad Dermatol* 1985;13:369-73. [PUBMED]
7. Bondeson J. Everard home, John Hunter, and cutaneous horns: A historical review. *Am J Dermatopathology* 2001;23:362-9.