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Eruptive Seborrheic Keratoses Associated with Erythrodermic Pityriasis Rubra Pilaris

Possible Role of Retinoid Therapy

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Schwengle LEM, Rampen FHJ. Eruptive seborrheic keratoses associated with erythrodermic pityriasis rubra pilaris. Acta Derm Venereol (Stockh) 1988; 68: 443–445.

A 74-year-old female patient with an erythrodermic pityriasis rubra pilaris developed multiple seborrheic keratoses during the early stage of the skin disorder. There was no evidence of an underlying internal malignancy. Initially, the patient was treated with etretinate. The seborrheic keratoses all faded away during the next 3–4 months without any specific treatment. The possible role of retinoid treatment in the resolution of seborrheic keratoses is discussed. *Key words: Erythrodermia; Sign of Leser-Trélat; Retinoids.* (Received December 12, 1988.)

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The sudden appearance of multiple seborrheic keratoses or the sudden increase in number and size of pre-existing seborrheic keratoses can be a manifestation of an underlying malignancy. This relationship is known as the sign of Leser-Trélat (1).

If strict criteria for this sign are applied, it is evident that in very few reported cases does the course of the seborrheic keratoses reflect the course of the tumour. It has therefore been questioned whether the association represents a genuine paraneoplastic sign (2). Statistical confirmation of the association is lacking, since only instances with a concurrent tumour are reported. Little is known about the frequency of seborrheic keratoses changing or growing without evidence of an underlying malignancy. Seborrheic keratoses or acanthomas resembling seborrheic keratoses may arise during the course of an erythrodermic condition (3, 4). The paucity of published descriptions of this association suggests that it is either very rare or else ignored by clinicians. We report here a typical case.

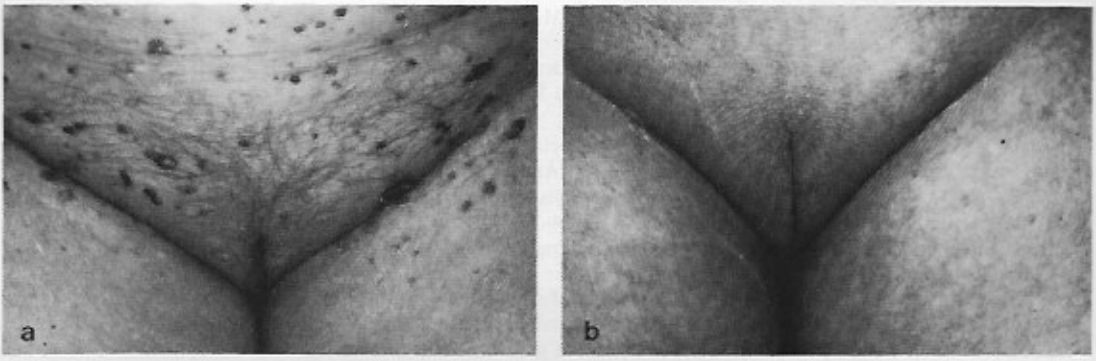

Fig. 1. Multiple seborrheic keratoses on the lower abdomen (*a*), with total clearing 3 months later (*b*).

CASE PRESENTATION

A 74-year-old woman with an erythrodermia of 1–2 months' duration was admitted to our clinic in January 1987. The skin condition had started on the hairy scalp and on the face, spreading rapidly over the entire body surface. The dermatological history was unrevealing. She used metoprolol for hypertension, but there was no temporal relationship. Cessation of the medication had had no effect on the erythrodermia. Histology, performed elsewhere, showed features compatible with 'seborrheic dermatitis'.

On admission she displayed a generalized exfoliative erythrodermia. On the trunk there were a few sharply demarcated islands of normal skin with some red follicular papules. On the elbows, knees, palms and soles a distinct hyperkeratosis was seen. There was only mild pruritus. The clinical diagnosis of pityriasis rubra pilaris with erythrodermia was supported by the histological findings: hyperkeratosis with parakeratosis, psoriasiform acanthosis, keratotic follicular plugging and a sparse lymphohistiocytic infiltrate around dilated capillaries in the upper dermis.

There were numerous seborrheic keratoses on the trunk, especially on the lower back, on the abdomen and in the submammary areas. The patient insisted that the majority of them were of recent date; they had emerged more or less simultaneously with the onset of the erythrodermia. Pre-existing seborrheic keratoses had become larger in the same period. Independent inquiry of the husband yielded very similar information.

A presumptive diagnosis of the sign of Leser-Trélat was made. Thorough clinical and laboratory evaluation disclosed only vague upper abdominal discomfort. No abnormalities were detected on X-ray of the stomach, gastroscopy and echography of the upper abdomen. A mild elevation of the serum liver enzymes was attributed to the etretinate therapy which she had started 3 weeks before admission (0.4 mg/kg body weight). During her stay in the hospital the etretinate dosage was gradually increased to 1.0 mg/kg, with only slight alleviation of the erythrodermia. Instead, the serum liver enzymes increased further and after 3 months the etretinate therapy had to be discontinued. During the retinoid treatment the seborrheic keratoses showed a striking resolution. Some of the involuting keratoses exhibited an inflammatory response, with redness followed by necrosis of the lesion. Histology of a regressing lesion revealed a mononuclear cell infiltrate.

Topical and systemic steroids, tar preparations and UVB phototherapy occasioned a further clearing of the pityriasis rubra pilaris. Meanwhile, the keratoses had all disappeared without any 'specific' treatment (Fig. 1). After 7 months the patient was discharged with minimal residual erythrodermia. At the time of discharge there were no signs of an underlying malignancy at thorough clinical and laboratory work-up. The liver function tests had normalized.

DISCUSSION

Had we found an internal malignant neoplasm in this patient, we would have made a diagnosis of the sign of Leser-Trélat. This sign is characterized by the eruptive appearance of multiple seborrheic keratoses in association with an underlying malignancy. Over 50 cases have been reported so far (1). Whether the 'sudden' appearance of seborrheic keratoses is a valid paraneoplastic sign remains a matter of debate. The follow-up period of over half a year with-

out evidence of an underlying tumour reliably excludes the presence of this sign in our patient. We are also confident that the keratoses had emerged rather rapidly in conjunction with the dermatosis. The patient and her husband volunteered a remarkably similar history.

Williams reported 4 patients with seborrheic keratosis-like lesions on areas of skin affected by eczema (3). Two similar cases were presented by Barrière et al (4). In both studies it was reported that after resolution of the dermatosis the acanthomas spontaneously disappeared. We believe that our patient fits the description by Williams and by Barrière et al.

Involution of seborrheic keratoses after control of an exfoliative erythrodermia has also been observed by Berman & Winkelmann (5). Histologic examination showed a mononuclear cell infiltration of the seborrheic keratoses. The present case confirms these findings. Several involuting seborrheic keratoses in our patient showed an inflammatory response with redness and necrosis.

The role of etretinate in the regression of the keratoses in our patient is not clear. To our knowledge, systemic retinoid therapy has not been reported to influence the course of seborrheic keratoses. On the other hand, Schumacher & Stüttgen reported an effect of topical retinoic acid in 8 patients with seborrheic keratoses (6). In our patient the seborrheic keratoses regressed further after withdrawal of etretinate therapy and they did not recur during follow-up. It is therefore uncertain whether the lesions regressed after (partial) control of the cutaneous inflammation or as a result of the etretinate therapy.

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The 'Tape-method': A New and Simple Method for Quantitative Culture of Pityrosporum Yeasts

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Wikler JR, de Haan P, Nieboer C. The 'tape-method': a new simple method for quantitative culture of Pityrosporum yeasts. Acta Derm Venereol (Stockh) 1988; 68: 445–449.

A new method for quantitative culture of Pityrosporum yeasts, the 'tape-method', is presented. Samples for culture were taken from the skin by stripping with 1 cm^2 of tape, whereafter the tapes were placed over a drop of sterile olive oil which was pipetted on a Sabouraud medium. Plates were incubated at 37°C, and after 7 days the numbers of Pityrosporum colonies growing under the tapes were counted. With this method a difference in numbers of Pityrosporum colonies between seborrheic dermatitis and normal skin could be discerned. This difference was significant. It appeared that two successive strippings were sufficient for quantitative culture. The 'tape-method' appeared to be a reliable and inexpensive diagnostic tool. (Received November 2, 1987.)

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