

Hypertrichosis Lanuginosa Acquisita

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Hypertrichosis lanuginosa acquisita was observed in a female patient with stage IV malignant melanoma and also diffuse melanosis of the skin. The patient died within 2 months after the appearance of HL. Key words: Malignant melanoma; Paraneoplastic symptom.

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Hypertrichosis lanuginosa (HL) is characterized by generalized or localized excessive growth of lanugo hair (1). The acquired form is often associated with malignancies of different organs, which is why it can be regarded as a paraneoplastic symptom. According to the literature available to us the association of malignant melanoma with HL has not been previously described.

CASE REPORT

A 32-year-old woman was operated on account of an ulcerated tumour, which had been expanding on the inner surface of her left knee. The histological examination of this tumour (1987) verified a malignant

melanoma of the superficial spreading type, Clark level V and 3.3 mm invasion.

Dacarbazine was given for half a year, during which a regional lymph node metastasis developed. After the removal of the latter, combined cytostatic treatment was administered (Elobromol and Adriamycin). She was reoperated because of the recurrence of the regional metastasis. After a symptom-free period of 6 months there was another recurrence in the regional lymph nodes.

She was admitted to the Dermatological Clinic in Debrecen in March, 1989. At that time, in spite of her good general condition, in the left lower part of the abdomen an immobile, non-tender tumour the size of a baby's head was palpated, and in the left inguinal region two tumours covered with bluish pigmented skin were found. The inguinal tumours were immobile. No other metastases (chest, skull, bone) were discovered. Surgeon's and gynecologist's opinion: inoperable metastases. Combined cytostatic therapy was given again after routine laboratory investigations. The treatment caused serious leukopenia (wbc 1.2 G/l), so the treatment had to be interrupted. Co 60 irradiation was given to the abdominal and inguinal metastases (doses 2×200 Gy), after which the metastases became smaller.

In May 1989, the patient's skin became bluish-silvery all over her body, and light coloured thin, 1-cm-long hair began to grow on her face (cheeks, forehead, chin) (Fig. 1). Her general condition and the size of the tumours mentioned above were unchanged. The values of testosterone, estrogen hormones and urine 17-keto-steroids showed no alterations.

From June 1989 she complained of weakness, and was therefore given symptomatic therapy. Anemia and abdominal pain were also

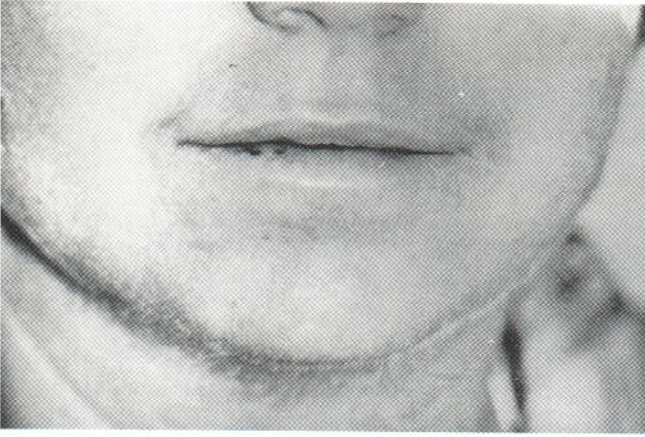


Fig. 1. Increased growth of soft unpigmented hair on the patient's face.

present. On the 2nd of August 1989 paraplegia and urinary retention developed. On the 9th of August the patient died of acute cardiorespiratory failure.

At the autopsy, malignant melanoma metastases were found in the lymph nodes of all regions, in the spinal cord, in the ribs, liver, spleen, myocardium, endocardium, costal pleura, diaphragm, in the mucous membrane of the small intestines, omentum majus and mesenterium. The clinically noted abdominal mass was the left ovarium with tumorous infiltrate. The direct cause of death was the acute failure of the degenerated myocardium.

DISCUSSION

Hypertrichosis means increased hair growth without signs of virilization. Both its localized and generalized form can have several causes, e.g. genetic background, trauma, various medications, encephalitis and so on (1). In adulthood the excessive growth of soft, depigmented hair, appearing suddenly, is a paraneoplastic sign called "malignant down" by Fretzin (2) on account of its association with tumours of the internal organs. Lung, liver and mamma carcinomas have been reported (3, 4, 5).

Female predominance is usually seen. The cause of HL is unknown, although some kind of immunological or hormonal origin is suspected, but the few reported cases have not proved either of these hypotheses (5, 6). There is no correlation between the appearance of HL and the tumour prognosis (5, 6, 7). The examination of hormone levels (testosterone, estrogen, pregnandiol, choriogonadotropin, growth hormone, 17-ketosteroid) did not give abnormal values (8). Increased carcinoembryonic antigen values may accompany abdominal tumours (7). It is usually followed by other paraneoplastic signs: acanthosis nigricans, pigmentation of skin and mucous membranes, glossitis, keratosis pilaris, etc. (1, 3, 4, 9). Concerning the chronological order, the tumour appears first, followed by HL, though it can be *vice versa*, e.g. the HL calls attention to a tumour (4, 5). The removal of the tumour can result in the disappearance of the paraneoplastic symptom, whereas paraneoplastic signs noticed during tumour progression, like HL, cannot be influenced. Our patient developed HL in the IV clinical stage of malignant melanoma, and died in 2 months.

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