Seborrheic Keratosis: A case report
Bhuiyan ZH

Summary
A 72-years-old male patient reported to me at my chowmuhani outdoor chamber with numerous black sharply demarcated tumorous skin lesions. The lesions were located mostly over the chest, face and back. They were largely papules, plaques and nodular ones. Mucous membranes found free of lesions. Itching was moderate in nature. Patient told that while he was 40, he has noticed one flat sharply demarcated brown macule, which gradually became polypoidal over chest. In course of time the lesion gradually spreads over face, trunk and back, which increases its number and size. Under thorough clinical examination and histopathological report, it has confirmed a case of Seborrheic keratosis. Other than symptomatic treatment patient was treated with Liquid nitrogen (Cryosurgery) and Electrofulguration (Electro surgery) in six sessions with the interval of 15 days. Patient was completely cured with slight hypopigmented spot.

Introduction
Seborrheic keratoses are multiple oval, slightly raised, light brown to black, sharply demarcated papules or plaques rarely more than 3 cm in diameter, located mostly on the chest and back but also commonly involving the scalp, face, neck and extremities. The palms and soles are spared; "Seborrheic Keratoses" in these areas are usually eccrine poromas. These lesions can appear on any part of the body except mucous membranes. Seborrheic keratoses typically begins as flat, sharply demarcated brown macules. As they progress they become polypoidal, with an uneven surface. Follicular prominence is one of the hallmarks of Seborrheic keratoses. This can either be caused by pale follicular plugs within a pale lesion. Colors of these lesions can vary from a pale brown with pink tones to dark brown or black.

Some patients have hundreds of these lesions on the trunk. The age of onset is generally in the fourth to fifth decade. Some believe the pathogenesis of Seborrheic keratoses is a development resulting from a local arrest of maturation of keratinocytes that are normal in other respects. They usually originate de novo but may also evolve from lentigines. They may increase in number when the patient is gaining weight.

Histopathology of Seborrheic keratosis
The Seborrheic keratos is a combined hyperplasia of epidermis and supporting papillary connective tissue. Six histologic type-hyperkeratotic, acanthotic, adenoid or reticulated, clonal, irritated and melanoacanthoma are distinguished. All types of Seborrheic keratosis have in common hyperkeratosis, acanthosis and papillomatosis. The acanthosis in most instances is entirely due to upward extension of the tumor. Thus the lower border of the tumor is even and lies on a straight line that may be drawn from the normal epidermis at one end of the tumor to the normal epidermis at the other end. Two types of cells are usually seen in the...
Acanthotic epidermis: Squamous cells and basaloid cells. The former have the appearance of squamous cells normally found in the epidermis, whereas basaloid cells are small and uniform in appearance and have a relatively large nucleus.

Case report
A 72-years-old male patient named Shamsul Haque, a retired defense personal from Maizdee (Noakhali) reported to me on April 06 with numerous skin lesions over his exposed and covered areas of the body. He told that while he was 40 years of age he first noticed one flat, sharply demarcated brown macule over his chest. With the extension of time it gradually became polypoidal with rough surface. Then the lesion increases in respect of size, number and areas of involvement of the body. In course of time except palms, soles and mucous membrane whole body surface became involved. Frequently he felt moderate itching. During his active Service in Army, he was being treated in different CMHS, but the treatment was inadequate.

When his face became completely involved with keratotic lesion he felt embarrassed due to cosmetic purpose. Patient's socioeconomic condition is poor. He told that with the increase of his body weight, the number and size of the lesion gradually increases. One nodular lesion was taken from chest under L/A and sent for Histopathology. The report was a case of Seborrheic keratosis. Accordingly Cryosurgery and Electrofulguration was done simultaneously in six sessions with the interval of 15 days. Patient was completely cured and free of lesion except some hypopigmented areas over face and chest.

Discussion
Seborrheic keratoses are an annoyance. Lesions around the neck can catch on clothing, as can lesion around the waist. Others can grow to become cosmetically undesirable, whether on the face or on the trunk. Many can cause concern because of confusion with nevi and the thought that the lesion is becoming a malignant melanoma. Conversely dysplastic nevi or malignant melanoma can lurk in a forest of Seborrheic keratoses and be undetected until a late stage, posing a significant danger. The etiology of Seborrheic keratoses is unknown. In patients with a great number of Seborrheic keratoses, there may be a positive family history. This may well reflect a genetic propensity. Seborrheic keratoses have sometimes been blamed on sun exposure. There is a propensity for the large type of Seborrheic keratoses to develop in areas of intermittent sun exposure, such as the back and anterior chest.

Because of the verrucous appearance of Seborrheic keratoses, human papilloma virus (HPV) has also been suggested as a possible etiology. Epidermal growth factor (EGF) is implicated in the development of Seborrheic keratoses. The eruptive appearance of multiple Seborrheic keratoses (The sign of Leser-Trelat) in association with various internal malignancies and with concomitant Acanthosis nigricans, another epidermal hyperplastic phenomenon, suggests the possibility that a tumor-derived circulating growth factor or humoral factor may be involved in the pathogenesis of these lesions. Melanocyte hyperplasia is commonly seen in Seborrheic keratoses. It has been suggested that melanocyte or melanocyte-derived growth factors may have a role in the development of Seborrheic keratoses.

Conclusion
Seborrheic keratoses is not uncommon in our country but rural people are most frequently involved than Urban. Basal Cell Carcinoma and other common skin Cancers have been
Case Report

reported rarely in association with Seborrheic keratoses. Malignant melanoma in association with Seborrheic keratoses has rarely been reported. It has been suggested that Basal Cell carcinoma, Squamous Cell carcinoma, and Melanoma associated with Seborrheic keratoses may arise from the basaloid cell, spinous cells and melanocytes that comprise Seborrheic keratoses. Most likely, however, malignant association with Seborrheic keratoses represent a Collision phenomenon.

References
10. Andrew's diseases of the skin, Clinical Dermatology- 9th edition page- 804.