CASE REPORT

A 27-year-old male presented with a 5-year history of velvous brownish lesions on his entire back. The brownish papules initially appeared on the central region of the back with subsequent peripheral extension. Mild itch was noted especially after taking a shower. Skin examination revealed numerous verrucous brownish papules arranged in a specific pattern, which were confluent in the center and reticulated at the periphery (Fig. 1). Skin scrapings for potassium hydroxide examination did not show any hyphae. The patient was otherwise in good health. Serum sugar, hemoglobin A1c (HbA1c), free thyroxin (FT4), thyroxin stimulating hormone (TSH), and erythrocyte sedimentation rate (ESR) were all within normal limits. Histopathologically, the epidermis showed hyperkeratosis, acanthosis, and papillomatosis, and some spores were noted in the corneal layer (Fig. 2).

Fig.1
Numerous verrucous brownish papules confluent in the center and reticulated at the periphery over the central back.

Fig.2
The epidermis showed hyperkeratosis, acanthosis and papillomatosis. (H&E, x40)
DIAGNOSIS: Confluent and Reticulate Papillomatosis

DISCUSSION

Confluent and reticulate papillomatosis (CRP) was first reported by Gougerot and Carteaud in 1927. This rare disease often affects young people. It usually begins as asymptomatic, discrete, flat-topped, light-brownish papules, which are 2 to 4 mm in diameter. They soon become dark brownish with their surface resembling a flat wart. The papules increase in number and size by peripheral extension. Those centrally located coalesce into a diffuse plaque, while those peripherally located spread out into a pigmented reticulated pattern. CRP usually begins on the center of the back and abdomen, and spreads upward and outward on the breasts, shoulders, and nape. The progression of the disease is usually slow, with occasional spontaneous regression.

The etiology of CRP is still obscure. In 1969, Roberts et al. first cultured Pityrosporum orbiculare from the CRP lesions, and proposed that CRP might be an abnormal host reaction to heavy P. orbiculare colonization. However, a Japanese series reported that only 13.6% of CRP patients (6/44 cases) had fungal elements. Endocrine abnormalities, such as diabetes mellitus, thyroid disease, and obesity or rapid weight gain had been found to be associated with CRP. Besides, abnormal keratinization and follicular bacteria were considered to be associated with CRP because some patients respond to treatment with vitamin A, retinoid, or various antibiotics.

There was no specific histopathological change for diagnosis of CRP. Most cases reported had nonspecific pathological changes, such as hyperkeratosis and papillomatosis.

The response to therapies in CRP patients has varied considerably. Antifungal agents such as 10% sodium thiosulphate and selenium sulphide were reported to be effective for CRP. Their effect was limited to patients with P. orbiculare in the skin lesions. The effectiveness of antibiotics, such as azithromycin and cefdinir, in treating CRP was established, but their mode of action was uncertain. Topical tretinoin cream and oral isotretinoin were also reported to be effective.

We treated this patient with oral ketoconazole 200mg/day and 0.05% topical tretinoin cream. The skin lesions improved gradually after two weeks of treatment. After four more weeks of topical tretinoin cream treatment alone, the eruptions had almost completely disappeared. No recurrence of the eruptions has been observed till now.

REFERENCES