

Papillomatosis Cutis Lymphostatica - Case Report

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Abstract

Observation: Papillomatosis cutis lymphostatica is a rare disease that affects mostly the patients in middle age, in lower legs previously affected by vascular changes. The disease is mostly without subjective symptoms it is rarely accompanied by itching, pain and discomfort. There is no effective treatment, but the disease can be put under control by a local treatment with urea even though that cannot guarantee total relapse of the disease.

Introduction

Papillomatosis cutis lymphostatica is a rare disease that affects mostly the patients in middle age, in lower legs previously affected by vascular changes. It affects mostly the patients who suffer from varicose veins, obesity, lymph stasis, the patients who did have recidivism of erysipelas and complications like elephantiasis and also have difficulties with venous circulation. The disease is mostly without subjective symptoms rarely accompanied by itching, pain and discomfort. There is no effective treatment, but the disease can be put under control by a local treatment with urea even though that cannot guarantee total relapse of the disease [1, 2].

Case Report

We report a case of 52 year old male with onset of the disease in age 48. He presented with multiple skin colored papillomatosis changes that forms

a confluent tumorous papillomatosis mass on the forefeet and feet fingers of both legs (**Figure 1**). The patient was diagnosed 5 years ago with a phlebothrombosis of the deep femoral vein of the left leg, and has a 7 year history of the diabetes mellitus type 2. Four years ago the patient was diagnosed with gastric ulcer, and a gastroscopy was performed to rule out gastric malignity. The rou-



Figure 1. Skin colored papillomatosis changes on the forefeet and feet fingers

tine analyses showed high level of glucose 9,8 (normal range 3,8-6,1mmol/L) and cholestrol 8(normal range<6,5 mmol/L) and a mild anemia – hematocrit 30(normal range35-45).The biopsy with a total excision of one papular change was performed. Echo Doppler was performed and showed a partial thrombi in left deep femoral vein. After the evaluation the diagnosis was also approved by a vascular surgeon. Because the patient was under the treatment of anticoagulants, the biopsy of the skin was not performed.

The patient was treated with Penicilline and after two week treatment the cryotherapy was applied two times a week, for a two week and since the results was poor the retinoid cream was applied during the one month period. However the response was not ideal, but the patient still did follow the cryotherapy in outpatient clinic after he left the hospital for another two weeks.

Discussion

Papillomatosis cutis lymphostatica is a rare disease that can appear in lymphadematosis base that is primary or it can be caused by obesity that initially forms cellulites and in a final stage leads to papilomatosis cutis lymphostatica with the consequence like disfiguration [3]. Also the change is a companion in some rare cases of hypostatic dermatitis and varicose veins. The neoplasms, heart failure, trauma, obesity and hypothyroidism [4] are also some of the causes. The disease affects the lower limbs especially the dorsal aspect of the toes [5, 6]. The diagnosis is made from the clinical signs and skin biopsy. The biopsy shows reactive papilomatosis changes with multiple lymph plexus.

The treatment consists of debridement of hyperkeratotic changes, exfoliation of the dead cells and local treatment that made a soft peeling of the papilomatosis growth. The cryotherapy and surgery is sometimes performed. Also the cream that contains urea is helpful.

The topical and oral retinoids are also successful in a treatment of epidermal proliferation and inflammation [1]. The most commonly used drugs in these cases are acitretin and tarazotene [1]. Based on a origin of lymphoedema there are cases where the antibiotics are the choice therapy, in a treatment of underlying erysipelas. The best

results are made with a long term of penicillin or cephalosporin's to prevent recidivism [1].

The compression with elastic bandage may be helpful [7].

The surgery is performed in the cases where other forms of treatment does not show any success, and this action includes debridement [8] anastomosis, and lymphatic transplantation.

Conclusion

Papillomatosis cutis lymphostatica is a chronic disease with the previous conditions that compromise the lymphatic drainage and the history of many diseases like, chronic vein stasis, mechanic obstruction that leads to a vein or lymphatic stasis, swelling of the lower limb due to heart failure, metabolic disease or hormonal persisting disease [1, 2, 4, 9]. The final stage is deformity, where the finding is edematous limb with a many hyperkeratotic and verrucous changes.

The therapy consist of a treatment of the primary disease and local therapy like cryotherapy, retinoids, and surgery [10, 11].

The diagnosis is made by the clinical findings, anamnesis, and finally biopsy of the skin.

The differential diagnosis includes: mycotic disease of the skin, tuberculosis verrucosa, verrucae vulgaris, filariasis etc.

References

1. Castellani A. Researches on elephantiasis nostras and elephantiasis tropica with special regard to their initial stage of recurring lymphangitis (lymphangitis recurrens elephantogenica) J Trop Med Hyg 1969; 72: 89–97. PMID: 5769718
2. Sisto K, Khachemoune A. Elephantiasis nostras verrucosa: a review. Am J Clin Dermatol 2008; 9: 141–146. PMID: 18429642
3. Schissel DJ, Hivnor C, Elston DM. Elephantiasis nostras verrucosa. Cutis 1998; 62: 77–80. PMID: 9714902
4. Castellani A. Elephantiasis nostras. J Trop Med Hyg 1934; 37: 257–264.
5. Duckworth AL, Husain J, Deheer P. Elephantiasis nostras verrucosa or "mossy foot lesions" in lymphedema praecox: report of a case. J Am Podiatr Med Assoc 2008; 98: 66–69. PMID: 18202337
6. Boyd J, Sloan S, Meffert J. Elephantiasis nostrum verrucosa of the abdomen: clinical results with taza-

- rotene. J Drugs Dermatol 2004; 3: 446–448. PMID: 15303792
7. Bergan JJ, Schmid-Schonbein GW, Smith PD, Nicolaides AN, Boisseau MR, Eklof B. Chronic venous disease. N Engl J Med 2006; 355: 488–498. PMID: 16885552
 8. Chernosky ME, Derbes VJ. Elephantiasis nostras of the abdominal wall. Arch Dermatol 1966; 94: 757–762. PMID: 4224251
 9. Kakati S, Doley B, Pal S, Deka UJ. Elephantiasis Nostras Verrucosa: a rare thyroid dermopathy in Graves' disease. J Assoc Physicians India 2005; 53: 571–572. PMID: 16121817
 10. Zouboulis CC, Biczko S, Gollnick H, et al. Elephantiasis nostras verrucosa: beneficial effect of oral etretinate therapy. Br J Dermatol 1992; 127: 411–416. PMID: 1419764
 11. Iwao F, Sato-Matsumura KC, Sawamura D, Shimizu H. Elephantiasis nostras verrucosa successfully treated by surgical debridement. Dermatol Surg 2004; 30: 939–941. PMID: 15171776