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Dermato-venereological Quiz

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A 67-year-old gentleman was referred for suspected genital wart. He presented with asymptomatic warty growth over the scrotum for three months. He had unprotected venereal exposure 6 month before the clinical presentation. He denied any other genital symptoms. On physical examination, there was a solitary 2 cm x 0.5 cm warty erythematous plaque over the scrotum (Figure 1). Incisional biopsy was performed and histopathology sections were shown in Figures 2 and 3.

Figure 1. Erythematous plaque over scrotal wall.

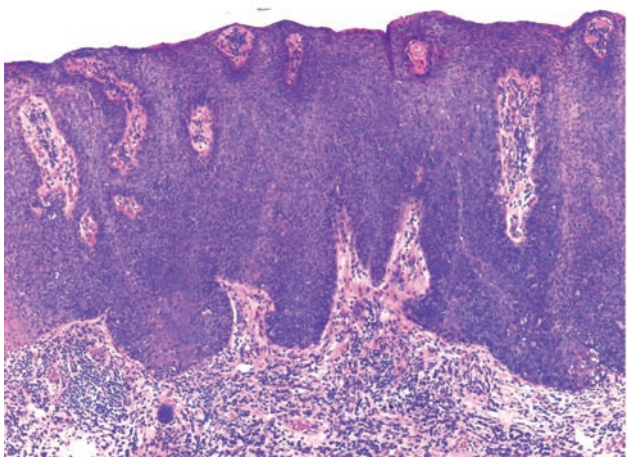

Figure 2. The epidermis is thickened with the keratinocytes showing increased nucleo-cytoplasmic ratio and nuclear hyperchromasia. (H&E, original magnification x 10)

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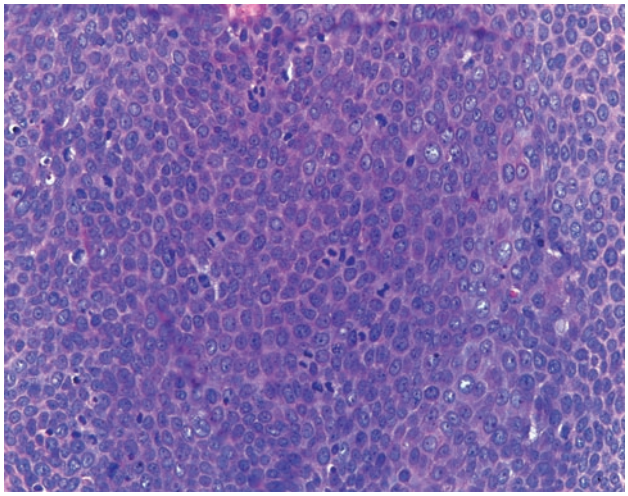

Figure 3. Multiple mitoses are present in different levels of the epidermis. (H&E, original magnification x 40)

Questions

1) What are the clinical differential diagnoses?
2) What are the histopathological features?
3) What is your diagnosis?
4) What are the treatment options?

(Answers on page 175)

Answers to Dermato-venereological Quiz on pages 164-165

1) The clinical differential diagnoses of solitary erythematous plaque over the scrotum include genital wart, lichen simplex chronicus, psoriasis, extramammary Paget's disease, Bowen's disease, squamous cell carcinoma and irritated seborrhoeic keratosis.

2) Histopathological section showed full thickness epidermal cytological atypia in the form of nuclear pleomorphism, hyperchromasia and frequent mitoses.

3) The diagnosis is Bowen's disease. It is a squamous cell carcinoma (SCC) in situ, with the potential to progress to SCC in three to five percent of cases. Etiologic factors include ultraviolet radiation exposure, chronic arsenic exposure, immunosuppression, exposure to ionizing radiation, and infection by human papillomavirus.

4) The choice of treatment will depend on the availability of expertise and facilities, as well as the patient's general condition and preference. In general, treatment methods include surgical and destructive therapies, topical therapies, and non-surgical ablative therapies. Surgical and destructive therapies include excision, Mohs micrographic surgery, curettage with or without electrocautery, chemoablation with trichloroacetic acid, and cryosurgery. Topical therapies include 5-fluorouracil and imiquimod cream. Non-surgical ablative therapies include radiotherapy, laser ablation and photodynamic therapy. Complete excision which permits histopathologic evaluation to exclude invasive SCC is the preferred treatment if condition allows.