Papillomatosis cutis lymphostatica: a sign of chronic edema

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INTRODUCTION

Papillomatosis cutis lymphostatica (PCL), or elephantiasis nostras verrucosa, is a rare, benign, and asymptomatic condition affecting usually the lower legs and resulting from chronic lymphedema [1]. Herein, we report a new sporadic case of PCL.

CASE REPORT

An obese 53-year-old male presented himself to our department with lymphedema of the left leg and ulcerated lesions evolving for two weeks prior. His medical history included epilepsy since childhood, mental retardation, chronic venous insufficiency, and chronic lymphedema complicated by recurrent ulceration and cellulitis. Over the previous four years, he had developed verrucous and papillomatous lesions on the left leg. A physical examination revealed an edematous leg with multiple painless coalescent verrucous skin-colored papules with a smooth or hyperkeratotic surface on the left lower leg surrounding the ulceration. The lesions were associated with oozing. A skin biopsy revealed hyperkeratosis, verrucoid acanthosis, and papillomatosis of the epidermis with moderate perivascular inflammatory infiltration of the dermis. A diagnosis of papillomatosis cutis lymphostatica (PCL) was reached based on histopathological and clinical findings. Our patient received lymphatic drainage and locally 5% salicylic acid.

ABSTRACT

An obese 53-year-old male presented himself to our department with lymphedema of the left leg and ulcerated lesions evolving for two weeks prior. His medical history included epilepsy since childhood, mental retardation, chronic venous insufficiency, and chronic lymphedema complicated by recurrent ulceration and cellulitis. Over the previous four years, he had developed verrucous and papillomatous lesions on the left leg. A physical examination revealed an edematous leg with multiple painless coalescent verrucous skin-colored papules with a smooth or hyperkeratotic surface on the left lower leg surrounding an ulceration 10 × 5 cm in size (Fig. 1). The lesions were associated with oozing. A skin biopsy revealed hyperkeratosis, verrucoid acanthosis, and papillomatosis of the epidermis with moderate perivascular inflammatory infiltration of the dermis (Fig. 2). A diagnosis of PCL was reached based on histopathological and clinical findings. The patient received lymphatic drainage and locally 5% salicylic acid.

Key words: Chronic lymphedema; Papillomatosis cutis lymphostatica; Elephantiasis nostras verrucosa

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by interfering with epidermal proliferation and inflammation [3-5].

Topical keratolytic agents can be an option. Surgical interventions and CO₂ laser excision might be performed if other treatments fail.

**CONCLUSION**

As far as we know, few cases of PCL have been reported, and PCL remains a vulnerable area in the occurrence of infection and neoplasia. We insist on the importance of its early recognition to prevent complications.

**Consent**

The examination of the patient was conducted according to the principles of the Declaration of Helsinki.

The authors certify that they have obtained all appropriate patient consent forms, in which the patients gave their consent for images and other clinical information to be included in the journal. The patients understand that their names and initials will not be published and due effort will be made to conceal their identity, but that anonymity cannot be guaranteed.

**REFERENCES**