DEB/LP/VORI=SCC/KA

Med Derm Society Annual Meeting

Pearls of Wisdom: Case Presentation

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Objectives

- Pitfall: hypertrophic LP diagnosed as SCC
- Triggers of KA-like proliferations
- ?Speculative pathogenic mechanism
- Treatment of "SCC/KA" medically

Unobjectives

- Solve the KA/SCC debate

History

- 67-year-old woman with multiple keratotic nodules on the legs
- Biopsies read as “squamous cell carcinomas”

KA-Like Lesion in Hypertrophic LP

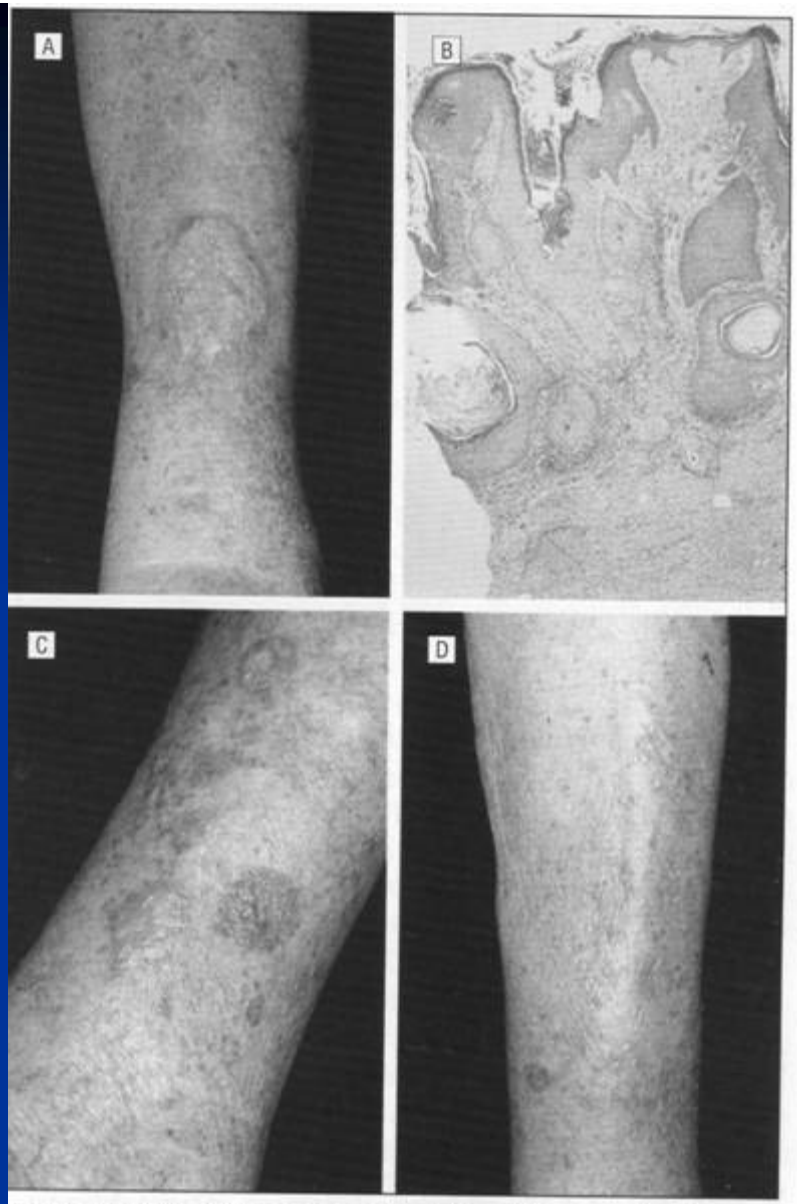
- Caucasian women > 60 years with extensive sun damage on legs
- Lesions may be of sudden onset
- Only KA/SCC-like lesions are seen initially
- Lesions of LP may not be evident
- Drug induced—HCTZ, pravastatin, beta blockers.

OBSERVATION

Hypertrophic Lichen Planus–Like Reactions Combined With Infundibulocystic Hyperplasia

Pathway to Neoplasia

Steven Kossard, FACD; Carol Thompson, PhD; Gary M. Duncan, FRACS



igure 1. Patient 1. A, Violaceous plaque with keratotic rim on the left leg. , Skin biopsy specimen demonstrating infundibulocystic hyperplasia with chenoid inflammation and irregular lobules of keratinocytes penetrating into he mid dermis (hematoxylin-eosin, original magnification ×40). , Violaceous lichen planus–like reaction on the right leg at sites of ryotherapy. D, Appearance of the left leg 1 year after commencing eatment.

KA in Hypertrophic LP
Medical Treatment

- Stop triggering medication
- Topical Steroids
- Topical Steroids with Occlusion
- Intralesional Steroids
- Antimalarials
- Intralesional 5FU to refractory lesions
- Oral Retinoids

Triggers of squamoproliferative lesions—KA/SCC

- LP/DLE
- Voriconazole-associated photosensitivity
- Chronic wounds
- Dystrophic EB
- Trauma
- Prurigo nodularis

Dermis and SCC/KA

- The dermis is important in development and behavior of squamoproliferative lesions
- It's not just the seed--it's also the soil it grows in.

- Mediated in part by Insulin-like growth factor (IGF) secretion by fibroblasts and IGF receptor expression on keratinocytes
- IGF-R binding of IGF by keratinocytes is pro-apoptotic (pathway to get rid of DNA-damaged keratinocytes)
- Fibroblasts are deficient in severely sun-damaged skin
- Geriatric fibroblasts have reduced IGF production
- Bottom line: If your dermis/BMZ is not good, you can grow epidermal neoplasms

AND

- Retinoids increase expression of IGF-R on keratinocytes
- Stopping inflammation along the BMZ may allow the IGF--IGF-R binding to work
- Making new fibroblasts may control squamoproliferative lesions (that patient who had the horrible reaction to 5FU and never got an AK/SCC in that area)
- Fractionated laser/TCA/Dermabrasion for areas of multiple SCC's

What I learned in a Decade

And you in 15 minutes

- KA's appear with hypertrophic LP and the treatment is to treat the LP
- SCC/KA occurs in conditions that damage the BMZ/upper dermis
- The Dermis is important in determining the generation and behavior of squamoproliferative lesions (think of your garden)

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Thank you!

KA and Hypertrophic LP

Br J Dermatol 2003,148:592

- Are these KA's reactive? part of the LP? or SCC's with limited progression potential
- Impossible to know

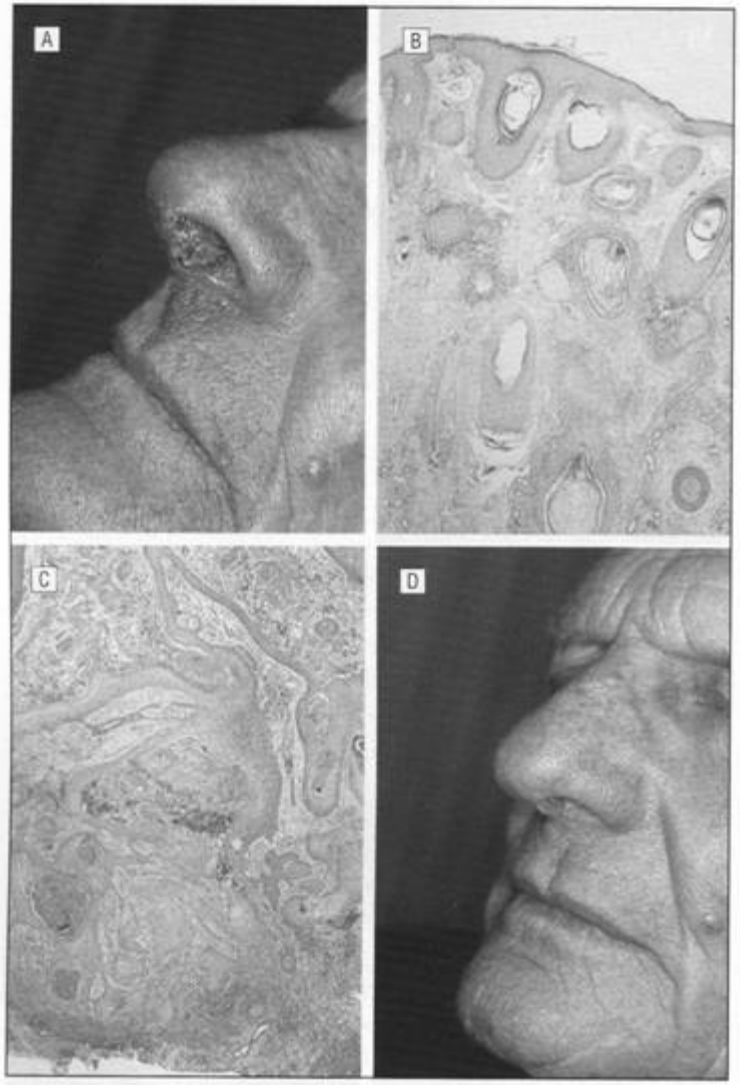

Figure 2. Patient 2. A, Ulcerated nasal columella with infiltrated violaceous plaque extending to the upper lip. B, Skin biopsy specimen of plaque revealed multiple dilated follicles outlined by prominent lymphocytic infiltrate resembling lichen planopilaris. C, Skin biopsy specimen from right nasal ala showing marked infundibulocystic hyperplasia, irregular cords, and lobules of keratinocytes penetrating through the full depth of the biopsy (hematoxylin-eosin, original magnification ×40 [B and C]). D, Appearance after 4 months of taking acitretin.

acitretin was continued for 20 months, and the area re-

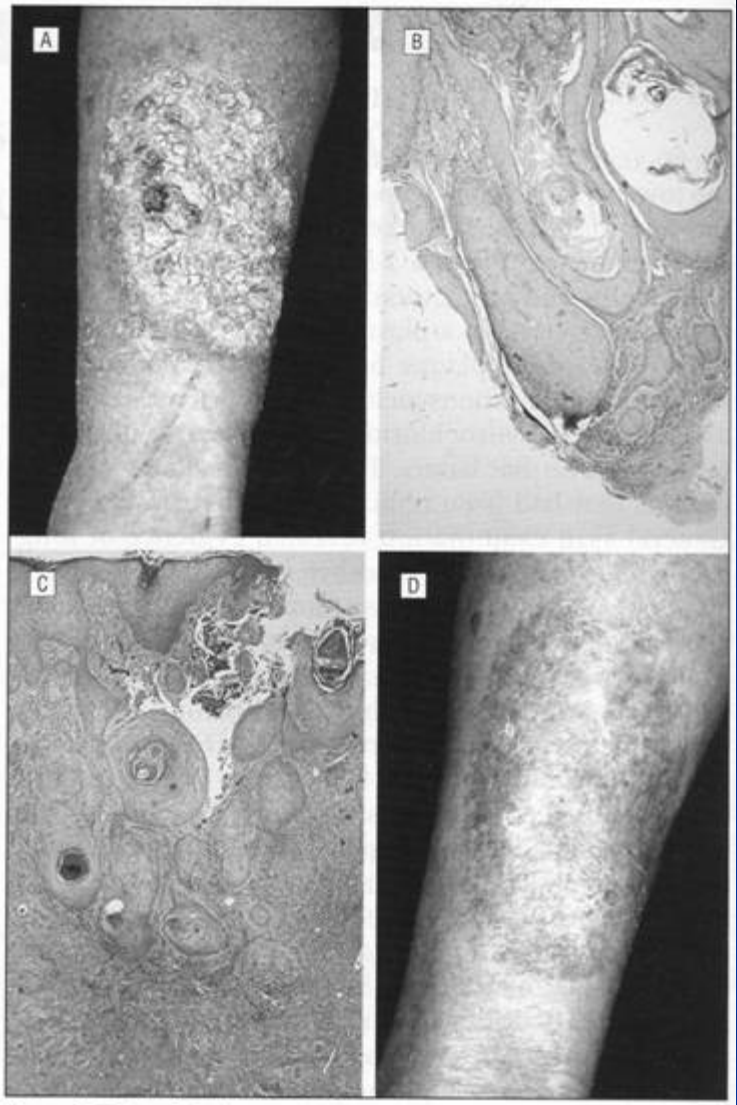

Figure 3. Patient 3. A, Hypertrophic verrucous nodules covering a skin graft on the left leg. B, Biopsy specimen from the left leg demonstrating marked infundibulocystic hyperplasia, with irregular buds of epithelium extending to base of the specimen with lymphocytic reaction. C, Biopsy specimen from nodule in graft on the right leg with a central cavity and series of irregular lobules of keratinocytes penetrating the mid dermis with lymphocytic inflammation (hematoxylin-eosin, original magnification ×40 [B and C]). D, Appearance of the left graft site 10 months after commencing treatment with acitretin.