Keloidalike Morphea

Sir,

Although localized scleroderma usually presents as well-circumscribed flat or depressed sclerotic lesions, the development of nodular or keloidlike lesions has also been reported. We describe a patient with localized scleroderma, who had flat elevated keloidlike lesions. These developed symmetrically on the neck, chest and back over 6 years.

CASE REPORT

A 61-year-old woman, without contributory personal or family history of keloid formation or rheumatoid diseases, came to our hospital in December 1994 for sclerotic skin lesions that had developed over 6 years. She had no history of injury on the neck, chest, back or face. Physical examination revealed irregularly pigmented sclerotic plaques that were nearly symmetrical on the neck, chest, back and face. The sclerotic skin on the neck limited the movement of the neck. Furthermore, the lesions on the neck, chest and back were elevated from the surrounding normal skin and appeared similar to keloid lesions (Fig. 1). She did not show any symptoms suggesting systemic scleroderma, such as Raynaud’s phenomenon, sclerodactyly, or nail fold bleeding.

Laboratory data showed no abnormalities on complete blood count. Biochemical tests revealed moderate liver dysfunction (GOT activity (111 U/ml; normal 4–11 U/ml) and GPT activity (111 U/ml; normal 4–11 U/ml)) due to fatty liver and slightly elevated aldolase activity (9.1 U/ml; normal 2.1–5.7 U/ml). Antinuclear antibody, antineutrophilic antibody, anti-topoisomerase I, anti-DNA, anti-Sm, anti-RNP, anti-SS-A, anti-SS-B and rheumatoid factor were all negative. A biopsy specimen from a keloidlike lesion on the chest showed thinned epidermis with basal pigmentation, and a thickened dermis composed of overlying homogenized collagen fibers. The hyalinized coarse collagen fibers that are often observed in keloids were absent. Perivascular mononuclear infiltration was sparse. Elastica van Gieson stain revealed a decreased number of elastic fibers.

Because of the progressive limitation of neck movement by the skin sclerosis, oral corticosteroid therapy (prednisolone 30 mg/day) was started and resulted in gradual improvement of the limitation of neck movement and skin sclerosis. At present, after 50 weeks, the patient is taking 12.5 mg/day of prednisolone. Skin sclerosis is remarkably improved, and the keloidlike elevation is also flattened to some extent.

DISCUSSION

Nodular or keloidlike scleroderma is considered by Jublonska to be a rare variant of localized scleroderma (1). The terms “nodular scleroderma” and “keloidlike scleroderma” are now used as synonyms (2–4). In 1894, Unna described a keloidlike variant of scleroderma as the rarest type of scleroderma (5). Since then over 20 cases have been reported as nodular or keloidlike scleroderma. Previously reported cases appear to represent two categories: (a) systemic scleroderma accompanied by a generalized distribution of nodules (3, 4, 6, 7) and (b) scleroderma without documented systemic involvement with localized and generalized nodules or plaques (2, 8–11). For the latter category, Micalezzi et al. proposed the designation “nodular morphea” to differentiate it from nodular eruption with systemic sclerosis (11). Nodular scleroderma or keloidlike scleroderma, reported previously, was described as

Fig. 1. Keloidlike sclerotic plaques on the chest were symmetrically arranged over the bones.

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nODULES WITH A CENTRAL DEPRESSION, THICKENED RED PLAQUES WITH IRREGULAR MARGINS (8) AND HANDSIZED TUBEROUSITIES (2). OUR PATIENT HAD NO CLINICAL OR LABORATORY EVIDENCE OF SYSTEMIC SCLEROSIS, SO THIS CASE WAS CONSIDERED IN THE LATTER CATEGORY OF NODULAR SCLERODERMA. UNLIKE THE RECENTLY REPORTED CASES OF "NODULAR SCLERODERMA", OUR CASE DID NOT PRESENT WITH NODULES IN SCEROTIC PLAQUE, BUT KEGOLYDALLY ELEVATED SYMMETRICAL PLAQUES. WE REGARD THIS CASE AS STRICTLY MEETING THE CRITERIA DESCRIBED IN THE ORIGINAL CASE OF UNNA'S "KEGOLDYALNÍCHE SKLEROERMIE", BECAUSE OF THE KEGLDYLKE APPEARANCE AND HISTOPATHOLOGY COMPATIBLE WITH LOCALIZED SCLERODERMA. IF "KEGOLDYLKE MORPHA" AND "NODULAR MORPHA" ARE CONSIDERED TO BE IN DIFFERENT CATEGORIES, THIS IS QUITE A RARE CASE OF "KEGOLDYLKE MORPHA" IN THE STRICT DEFINITION.

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Deep Dermal Invasion of Keratoacanthoma of the Face

Sir,
We here describe 2 patients with keratoacanthoma, whose lesions on the lip and the nose reached even the opposite mucosal surface of the lip or the ala nasi.

CASE REPORTS

Case 1
A 64-year-old Japanese man visited us because of a 3-cm, dome-shaped, center-depressed nodule on the right side of his jaw, which had been growing rapidly for the past 1 month (Fig. 1). An incisional biopsy specimen showed masses of slightly atypical, eosinophilic squamous cells. In the tumor masses, there were intraepithelial abscesses. Under a diagnosis of keratoacanthoma we closely followed him without any therapeutic intervention. During the next 6 weeks, the nodule still continued to expand and we noticed the development of multiple yellowish white spots. 1 mm in diameter, in the oral mucosal surface of the lower lip just corresponding to the site of the nodule (Fig. 2). We biopsied the nodule again and found only multiple epidermal cysts filled with horny material. Several weeks later, the nodule began to decrease in size gradually. Seven months later, we noticed total disappearance of the nodule with clearance of the whitish spots visible from the oral mucosa. No recurrence was observed during the following 9 years.

Fig. 1. Clinical appearance of keratoacanthoma on the right side of the jaw of Case 1.

Fig. 2. Multiple yellowish white spots in the oral mucosa of the right lower lip, corresponding to the keratoacanthoma in Case 1.