Sign of Leser-Trélat & cholangiocarcinoma: A rare association

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Ganubhau/ 75/M /Farmer/ref;Med II

- Abdominal distention
- Swelling of legs
- Generalised weakness
- Warty eruptions over trunk

3 months
• Referred for dermatological consultation for multiple, pruritic, tan to black warty eruptions of sudden onset
- Similar lesions over flanks & arms
H/O

- Weight-loss (~ 7 kgs)
- Loss of appetite 6 mths
- Fever off & on
- Consuming alcohol daily since 30 years (120 ml/day)
General examination

- Conscious, cooperative, well-oriented
- Febrile
- Cachectic with BMI- 17
- Pallor - +++
- Pedal edema
- Icterus ++
- No lymphadenopathy, cyanosis, clubbing
Systemic examination

• Per abdomen findings:

✓ Ascites & distended veins
✓ Splenomegaly
✓ Shifting dullness
✓ Absent bowel sounds
Dermatological examination
• Brown-black macules, papules, and plaques; present on trunk

Texture - waxy to velvety
‘Stuck-on’ appearance
Dermoscopy

Cerebriform pattern

Clinical
HPE

keratotic invaginations ("pseudohorn") cysts

Intraepithelial keratin ("true horn") cysts

Dermis - moderate inflammatory infiltrate

HPE - 100X H&E
Melanin incontinence in the basal layer

Papillomatosis, parakeratosis, acanthosis

Keratotic invaginations ("pseudohorn") cysts

Intraepithelial keratin ("true horn") cysts

Melanin incontinence in the basal layer

HPE 400X H&E
In view of appearance of

- Sudden, multiple, pruritic seborrheic keratosis
- In an aged cachectic, febrile icteric, pale patient
- With significant loss of weight & appetite

- Dermatological opinion was of Leser-Trélat sign; most likely paraneoplastic;

- Appropriate work-up to rule out underlying malignancy was advised
Lab investigations

• CBC : Hb- 8.8 g/dl

• TLC - 3600/ml

• ESR – 32mm

• RBC indices suggests- Macrocytic normochromic anaemia
• LFT – *Serum bilirubin & transaminases*

• RFT – Normal

• Urine - RE – normal;
  
  - ME – *Pus cells: 6-8,*

  Epithelial cells : 1-2 ;

  RBCs: 6-8
Ascitic fluid –

• **Gross**: Volume-2-3ml; yellowish; clear

• **Microscopy**: nucleated cells – 150/mm³

  *(lymphocytes 70%)*

• **Biochemistry parameters**:
  - Sugar
  - Protein
  - LDH – 39 SU
  - Albumin – 0.6 mg%
  - ADA – 35 u/l *(normal - <30/l)*
• HIV
• Hbs Ag – Negative
• HCV
• Sr. PSA – 0.4 ng/ml
USG abdomen

- Liver parenchymal disease
- Gross ascites
- Splenomegaly
- Changes of cystitis
- Minimal pleural effusion
- Borderline prostatomegaly
OGD *scopy* – grade II oesophageal varices with *portal hypertensive gastropathy* with *GAVE duodenitis*

2D ECHO – EF – 60% , *mitral valve annular calcification*, *aortic valve sclerosed*
CEPT Abdomen

- Mild central dilatation of intrahepatic biliary radicals in right and left lobes
• Common hepatic duct-common bile duct junction at porta hepatis not well visualized and showed wall thickening –

• **Infiltrating cholangiocarcinoma**
Discussion
Paraneoplastic dermatoses

Malignancy

Curth's postulates

- Concurrence
- Parallel course
- Site or cell specificity
- Statistical association
- Genetic association
Strength of correlation

Strong  Bazex syndrome
         Acanthosis palmaris (tripe palms)
         Florid cutaneous papillomatosis
         Primary amyloidosis
         Acquired hypertrichosis lanuginosa

Moderate  Sweet syndrome, Pyoderma gangrenosum

Weak   Acanthosis nigricans in isolation
        Acquired ichthyosis
        Leser–Trélat sign
Bazex syndrome

SCC of upper aerodigestive tract
Malignant acanthosis nigricans

Adenocarcinomas: intraabdominal; gastric (50%–60%)
Tripe palms (acanthosis palmaris)

Lung Ca. (most common)
Gastric Ca. (second)
Leser-Trélat sign

- Rare paraneoplastic cutaneous sign
- Refers to **sudden** onset and **dramatic increase** in the number and size of seborrheic keratoses
## Associations

<table>
<thead>
<tr>
<th>Non-malignant</th>
<th>Malignant</th>
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<tbody>
<tr>
<td>• Elderly</td>
<td>• <strong>Gastric, rectal, colon Ca</strong></td>
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<tr>
<td>• Eczema</td>
<td>• <strong>Lymphoproliferative dis. (CTCL, pre B cell LL)</strong></td>
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<tr>
<td>• Acanthosis nigricans</td>
<td>• Breast ca.</td>
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<tr>
<td>• Erythroderma</td>
<td>• Lung ca.</td>
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<tr>
<td>• HIV</td>
<td>• <strong>RCC, TCC-UB</strong></td>
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<tr>
<td>• Acromegaly</td>
<td>• <strong>Malignant haemangiopericytoma</strong></td>
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<td>• <strong>Metachronous Ca.</strong></td>
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</table>
• However, concurrence of Leser-Trélat sign with **cholangiocarcinoma**, as in our patient, is very rare

• Previous solitary report –

• 2\textsuperscript{nd} case to be noted in English literature till date

• 1\textsuperscript{st} case in Indian scenario
Prognosis and course

• It can appear 5 months prior to /10 months after the diagnosis of malignancy.

• Once diagnosed, prognosis is poor with average survival time of 10.6 months.
Take home message!

Seborrheic keratoses are very common in the elderly

**BUT**

Sudden, eruptive and pruritic ones

require further work-up