

SYNDROME OF LESER-TRELAT: A CASE PRESENTATION

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Summary

The abrupt onset of numerous seborrheic keratoses (Leser-Trelat sign) can evolve in association with an internal malignancy (Leser-Trelat syndrome). A 65-year-old man was seeking a dermatological consult for a pruritic eruption consisting in multiple seborrheic keratoses. The lesions had a precipitate onset and a rapid enlargement. The gastroscopy revealed a gastric carcinoma type Bormann III. Even if a strong physiopathological relation between seborrheic keratoses and internal malignancy is not yet established, all patients with Leser-Trelat sign should be evaluated for occult neoplastic disease.

Keywords: Leser-Trelat, seborrheic keratoses, gastric carcinoma.

Rezumat

Apariția bruscă a numeroase keratoze seboreice (semnul Leser-Trélat) poate evolua în asociere cu o afecțiune malignă (sindromul Leser-Trélat). Un bărbat în vârstă de 65 de ani a solicitat consult dermatologic pentru o erupție pruriginoasă constând din keratoze seboreice multiple. Leziunile apăruseră de scurt timp și se măreau rapid în dimensiuni. Examenul gastroscopic a decelat un carcinom Bormann de tip III. Deși o legătură fiziopatologică între keratozele seboreice și neoplaziile organelor interne nu a fost identificată se recomandă ca pacienții cu semnul Leser-Trélat să fie evaluați pentru o eventuală neoplazie.

Cuvinte cheie: laser-trelat, keratoză seboreică, carcinom gastric.

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Introduction

Numerous dermatological changes can reveal an underlying internal malignancy. In some cases the association is well defined and accepted (pemphigus, dermatomyositis, acrokeratosis of Bazex etc.) while in other this correlation is poor defined and not unanimous accepted (chronic urticaria, erythema multiforme, acne, acanthosis nigricans etc.). The surgeons Dr. Edmund Leser and Dr. Ulysse Trelat were separately and concomitantly searching to demonstrate that cherry angiomas are linked to internal malignancies. After 1900 their names were associated (by error or by extension) to the seborrheic keratoses eruption [1]. The Leser-

Trelat sign is described as the sudden appearance and rapid increase in size and number of seborrheic keratoses [2]. In 2000 it was proposed a definition for the syndrome of Leser-Trelat as a paraneoplastic syndrome in patients with the sign of Leser-Trelat in whom an occult malignancy was discovered after the appearance of the sign [3]. It is difficult to demonstrate the validity of this association as it is described in elderly, where both the seborrheic keratoses and the internal malignancies are not rare. A review of the literature [1] indicate that most frequent the syndrome of Leser-Trelat is associated with adenocarcinomas (of the stomach and of the breast) or with lymphomas.

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Case report

In December 2002 a 65 year old man was seeking a dermatological consult complaining of a pruritic eruption disposed on his upper and lower back (photo 1). The clinical examination revealed sessile exophytic tumors of round or ovalar aspect, with the diameter of 2 - 5 cm. The lesion surface was verrucous and friable or smooth, coloured brown-black respectively brown-red with numerous black keratotic plugs. On general examination epigastric tenderness was present.

The patient declared that the lesions developed rapidly, over a period of 6 months. The pruritus was severe, interfering with daily activities and sleep. The patient complained of the rapid development of the lesions in the last 60 days and of the pruritus intensification. He also noticed from 3 months an epigastric pain (burning type) that occurred after the meals. The patient was worried of a weight loss of 4 kg occurred during the last month. He described night sweats and a decreased appetite for this period of time. The patient did not observed changes in his stools. There was no family history of similar lesions of seborrheic keratosis.

Laboratory usual investigations showed hemoglobin of 11,5 g/dL, RBC $4,9 \times 10^6/\mu\text{L}$, WBC

$5,8 \times 10^3/\mu\text{L}$, PLT $180 \times 10^3/\mu\text{L}$, ESR 16 mm/h. All other values were in normal range.

One small, new arise lesion was excised and the dermatopathologic examination showed an acanthotic type of seborrheic keratosis (photo 2) with hyperkeratosis, papillomatosis and thick epidermis. Horny invaginations and horn cysts were also present. Large numbers of basaloid cells are present between the cysts.

The patient was referred to the Gastroenterology department for endoscopy. An ulcerative and infiltrative tumor (Bormann III) was identified on the lesser curve of the stomach (photo 3). An endoscopic biopsy specimen was not taken because of the risk of bleeding. The patient was then referred to the Oncology department for further surgical treatment. Histopathology of the tumor was relevant for adenocarcinoma and confirmed the stadialisation as Bormann III (ulceration with invasion of the gastric wall).

Discusion

The existence of Leser-Trelat syndrome is under debate and it is due to the high frequency of seborrheic keratosis in elderly people. The association of seborrheic keratosis with the internal malignancy can be fortuite. A



Photo 1. Seborrheic keratosis on the upper and lower back

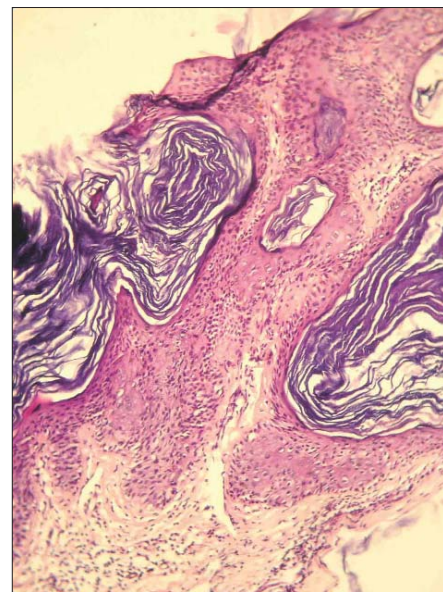


Photo 2. Acanthotic type of seborrheic keratosis



Photo 3. Endoscopic view of the gastric carcinoma

retrospective study concludes that the evidence for a causal relation between eruptive seborrheic keratoses and cancer is meager [4]. There are some case reports of patients with internal malignancies and paraneoplastic acanthosis nigricans in which the role of transforming growth factor- α (TGF- α) acts as epidermal inducer of hyperplasia [5]. More recent observations suggested that TGF- α produced by the internal malignancy could be responsible for the acute eruption of seborrheic keratosis [3]. In support of this theory is the observation that after the removal of the internal neoplasm there is a regression of the seborrheic keratoses [3].

Conclusions

The patients presenting the sign of Leser-Trelat should be carefully investigated for the existence of an occult malignancy. Physical examination, endoscopic investigation, radiologic and imaging studies (CT, MRI) should be performed by a medical team including dermatologist, gastroenterologist, and oncologist.

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Bibliography

- 1 Schwartz R.A. Sign of Leser-Trelat, *J Am Acad Dermatol* 1996; 35: 88-95.
- 2 Flugman S.L, McClain S.A, Clark R.A.F. Transient eruptive seborrheic keratoses associated with erythrodermic psoriasis and erythrodermic drug eruption: Report of two cases, *J Am Acad Dermatol* 2001; 45: S212-4.
- 3 Heaphy Jr. M.R, Millns J.L., Schroeter A.L. The sign of Leser-Trelat in a case of adenocarcinoma of the lung. *J Am Acad Dermatol* 2000; 43: 386-90.
- 4 Rampen H.J. The sign of Leser-Trélat: does it exist? *J Am Acad Dermatol.* 1990 Jul; 23 (1): 151-3
- 5 J.S.M. Yeh, S..E Munn. Coexistence of acanthosis nigricans and the sign of Leser-Trelat in a patient with gastric adenocarcinoma: A case report and literature review. *J Am Acad Dermatol* 2000; 42: 357-62.