A Case with the Sign of Leser-Trélat

Leser-Trélat Bulgusu Olan Bir Olgu

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ABSTRACT The sign of Leser-Trelat is an eruptive appearance or increase in the number of seborrheic keratoses. It is usually associated with underlying internal malignancy, especially gastric adenocarcinoma. Herein, we report a case of Leser-Trelat syndrome that preceeded the diagnosis of both prostate adenocarcinoma and cutaneous squamous cell carcinoma. Since Leser-Trelat syndrome may be the presenting sign of a new or recurrent tumour, we would like to emphasize the importance of the possibility of an underlying neoplasm and suggest appropriate screening.

Key Words: Paraneoplastic syndromes; keratosis, seborrheic

ÖZET Leser-Trelat belirtisi seboreik keratozların aniden ortaya çıkışı ya da sayısında artışı olarak tanımlanır. Özellikle gastrik adenokarsinom olmak üzere altta yatan iç organ maligniteleri ile ilişkilidir. Bu yazıda, hem prostat adenokarsinomu hem de kutanöz yassı hücreli karsinoma tanılarına öncülük eden Leser-Trelat sendromlu bir olguyu sunuyoruz. Leser-Trelat sendromu yeni ya da tekrarlayan bir tümörün ilk bulgusu olabileceği için, altta yatan neoplazm olasılığının önemini vurgulayarak olgularda gerekli tetkiklerin yapılmasını öneriyoruz.

Anahtar Kelimeler: Paraneoplastik sendromlar; keratoz, seboreik

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The Leser-Trélat sign is defined as sudden appearance of multiple seborrheic keratoses with quick evolution in size and number. This change has been usually secondary to the internal malignancy and is widely accepted as a paraneoplastic sign.[1,2] The majority of cases reported have an adenocarcinoma of gastrointestinal tract.[1-4] Herein, we report a case whose Leser-Trélat sign preceeded the diagnosis of both prostate adenocarcinoma and cutaneous squamous cell carcinoma. In this report, we want to emphasize the appropriate investigations and follow up should be undertaken in the presence of Leser-Trélat sign.

CASE REPORT

A healthy 75-year old man presented with a sudden development of multiple itchy pigmented lesions on his trunk within a year. His past medical

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history included that he had been followed up for benign prostatic hyperplasia (BPH) previously. Physical examination of the patient was normal. Dermatological examination revealed numerous (>100) sharply demarcated light-dark brown hyperkeratotic, slightly to moderately exophytic lesions having a diameter between 1-3 cm over the chest and back, giving a splashy appearance (Figure 1a-c). Clinical, dermoscopic and histopathological examination of the lesions were consistent with seborrheic keratoses (Figure 2). Due to the abrupt onset of lesions, the patient was scanned for presence of a malignancy. As a result, levels of prostate specific antigen were found to be higher [PSA: 10.67 (0-4) and free PSA 2.29 (0-1)]. The patient was consulted with urology clinic. Prostate biopsy was performed and the result was consistent with BPH. After 6 months of this biopsy, the patient was admitted to the urology clinic for urinary retention. The patient underwent transurethral resection of prostate (prostate TUR). Pathological examination of TUR material was accordance with high-intermediate-grade Gleason score 7 (3+4) prostate adenocarcinoma (Figure 3). On follow up, one year after the surgery, tumor recurrence and metastasis were not observed. On our follow up, the patient reported that during the past year, after prostate biopsy, a new lesion on his face had appeared and he had applied to another hospital for this new lesion. That new lesion was totally excised and the histopathological examination revealed squamous cell carcinoma (SCC) (Figure 4). No servical or any other lympadenopathy was detected. On follow up, dermatological examination revealed atrophic incisional operation scatris near his nose. Seborrheic keratoses of the patient stopped their speedy increase but did not regress.

DISCUSSION

Leser-Trélat sign is rarely seen and characterized by the presence of multiple seborrheic keratoses appearing abruptly in size and number, usually in association with an underlying malignancy.[1-3] Leser-Trélat sign may coincide with the diagnosis of occult cancer or either follow or predate it by months, sometimes years.[2-4]

Although it has also been described in nonmalignant conditions such as pregnancy, renal cyst, human immunodeficiency virus infection, erythroderma, heart transplantation; the majority of cases reported in connection with this sign have involved adenocarcinomas, most frequently gastric adenocarcinoma.[1,2,5,6] Other types of malignancies reported include hematological malig-

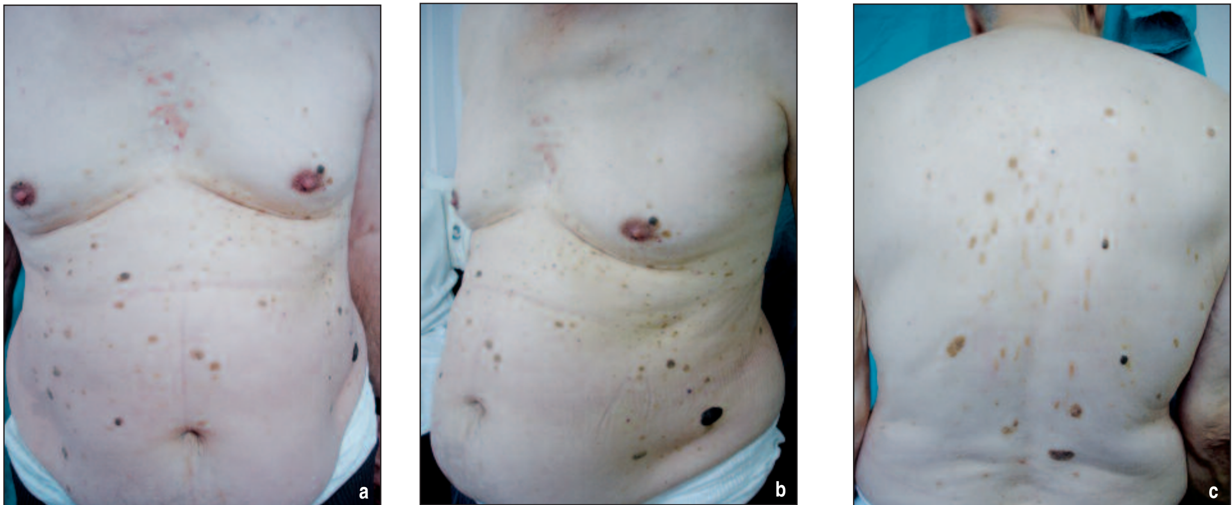


FIGURE 1: The appearance of hundreds of seborrheic keratoses localized over trunk.

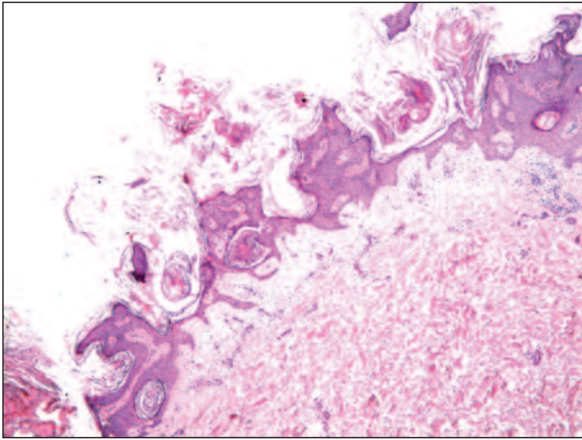
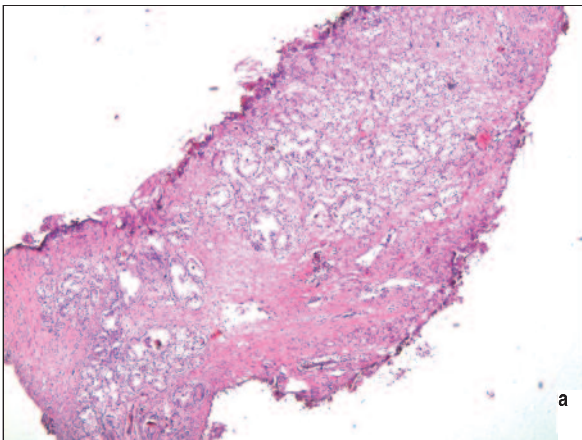


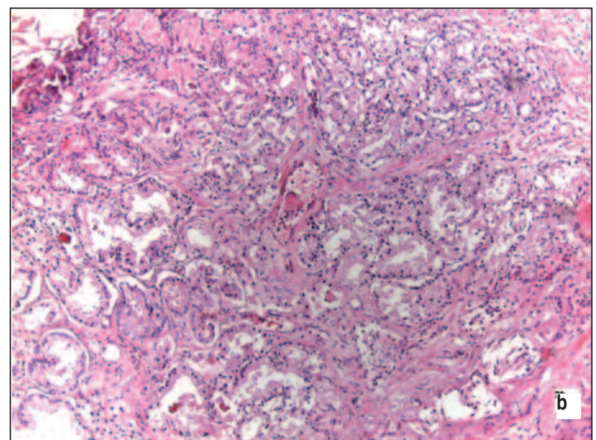
FIGURE 2: Hyperkeratotic type seboreic keratosis (HE x40).

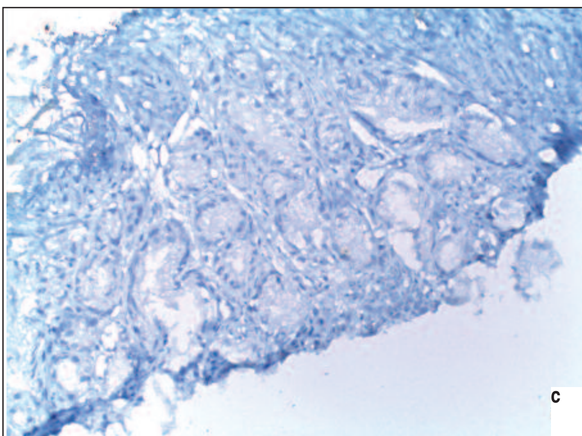
nancies, lung cancer, osteogenic sarcoma, leiomyosarcoma, melanoma, nasopharyngeal carcinoma.[1-3,7-9]

The cause of Leser-Trélat sign is stil uncertain but several hypotheses have been proposed to explain the concurrent nature of skin findings and malignancy. It is thought to be related to a tumor-produced humoral factor [eg, transforming growth factor-alpha (TGF-alpha)] which might be responsible for the acute eruption of the monomorphous seborrheic keratoses.[2,3]

The reliability of Leser-Trélat sign as clinical entity is a controversial subject.[1] Some authors suggest that association of seborrheic keratoses with malignancy might be coincidental, because both malignancy and seborrheic keratoses occur more frequently in elderly people. However, the abruptness of the eruption is striking and it should be distinguished from generalized seborrheic keratoses with gradual onset. Besides, description of young







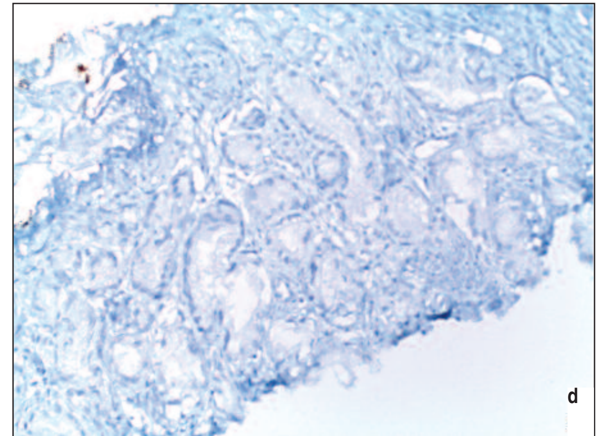


FIGURE 3: Prostatic adenocarcinoma, Gleason Grade 3,4 (Score: 7). Haphazardly arranged, irregular shaped glands are seen **(a)**, H.E x40, **(b)**, H.E x100. On immunostained slides no bazal cells can be found. **(c),** p63,x200 **(d)**, HMWCK (34BE 12), x200

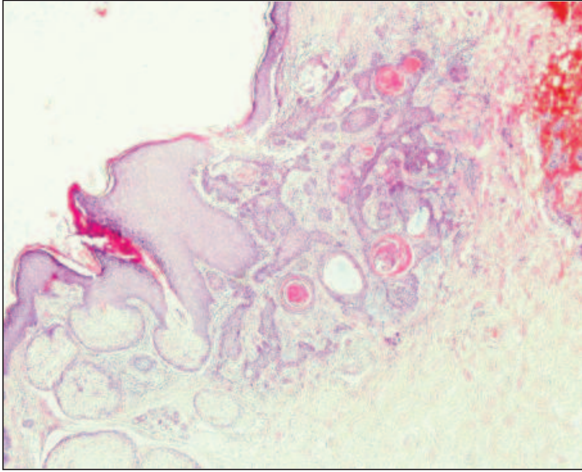


FIGURE 4: Keratinizing tumor nests in superficial dermis (HE, x40).

cases with Leser-Trélat sign with malignacy should alert us about this association.[5,10]

Due to the lack of controlled studies, it is still not possible either to demonstrate or reject the certainty of this entity. However, bearing in mind of several reported cases, we believe these cases should not be passed over and should be considered clinically suspicious. Herein, we report a case whose Leser-Trélat sign preceeded the diagnosis of both prostate adenocarcinoma and cutaneous SCC. Therefore, we would like to emphasize the importance of the possibility of an underlying neoplasm and suggest appropriate screening.

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