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Squamous cell carcinomas arising in seborrheic keratosis of external auditory canal: unusual situation

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Abstract: *We report an unusual case of seborrheic keratosis (SK) of theright external auditory canal in 78-year-old female patient, revealed by right malignant otitis externa andcaused impaired hearing, by obstructing the external auditory meatus.Surgical removal of lesion was performed and histopathological examination revealed association of SK with invasive Squamous cell carcinomas.We also reviewed and discuss the aetiology, clinical and histopathological featuresand treatment strategy of these disfiguring lesions.*

Keys words: *Seborrheic keratosis, external auditory canal, malignant otitis externa, Squamous cell carcinomas*

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I. Introduction:

Seborrheic keratosis (SK) is one of the most common, benign skin lesions in the elderly; it can be locatedanywhere on the skin except the palms and soles,but external auditory canal involvement is extremely rare [1].Although most of SKs are benign, rare cases can develop into malignant lesion, especially if they appear at an uncommon location and its size increases suddenly [2].

We report a case of patient in whom initially a diagnosis of Seborrheic keratosis made, but that later proved to be Squamous cell carcinomas arising in seborrheic keratosis, and very few similar cases are reported in the literature. We describe the case with a review of the literature, in order to alert physicians to this uncommon occurrence.

II. Case report:

78-year-old female patient came to our Otolaryngology Emergency Departmentcomplaining ofprogressive stenosis of the right auditory canal for 2 monthswhich caused impaired hearing associated with otalgia, purulent otorrhea and headache.She has received previously oral and local antibiotics, but the symptoms did not improve.She has a personal history of high blood pressure witch treated by antihypertensive drugs.

On examination the patient was febrile with temperature 38.2°C. She had a total obliteration of auditory external canal ear by inflammatoryexophyticmass, with swelling and redness of concha and she presented a pain and a highsensitivity to auricular movement, and purulent otorrhea**[figure1].**She did not present facial palsy and there was no specific finding on the parotid region, cervical regions or other similar skin on the rest of the body.

On pure tone audiometry, she had Sensorineural hearing loss with 40 db on the right and 20 db on the Left.

Computed tomographic (CT) of the temporal bones showed a homogenoussoft density mass that totally occluded the external auditory canal with tympanal bony destruction and opacification of mastoid air cells.The tympanic membrane was intact.There were noradiologic findings of cervical lymphadenopathy.

Bacteriological analysis of purulent otorrhea revealed Staphylococcus Epidermidis. The patient was initially diagnosed with malignant otitis externa and treated with intravenous antibiotic; there was improvement of inflammatory symptoms but persistent ofear pain and obliterate mass.Serology HIV was negative

Excisional biopsy was performed andthe histological analysis showed the aspect of Seborrheic keratosis with hyperkeratotic subtype**[figure 2**].

Subsequently, the patient underwent a surgical resection of the lesion with canaloplasty and intraoperative extemporaneous examination had confirmed the benignity nature. However, definitive histopathological analysis hasconfirmed association of SK with invasive Squamous cell carcinomas. Patient has refused Cervical Lymphadenectomy and was referred to oncology department to start radiotherapy. The evolution is satisfactory after a 6 month of follow-up.

III. Discussion:

Seborrheic keratosis is a common benign, pigmented cutaneous lesionthat develops from the accumulationof normal keratinocytes between thebasal layer and keratinizing surface [1]. The pathogenesis of SKs is not well understood and it is multifactorial. Factors includeolder age, ultraviolet light exposure, human papillomavirus infection, chronic skin infection and genetic predisposition [3].

SKs of ear are very rare. The greatest series reported in the literature include only 7 patients, witch 6 were located in EAC and one in auricle[4].

SKs may clinically mimic both premalignant and malignant lesions, and on close visual inspection, there are no clinical pearls that might differentiate from these lesions. Mostly,they appears as sharply demarcated, tan to brownishin color and has a slightly raised, verrucous surface with soft andfriable consistency [5]. SKsare usually asymptomatic, but sometimes they are associatedwith irritation, itching, pain, or bleeding and redness.In rare cases, its increasing of size onEAC can cause loss conductive hearing loss [6]. In our case, inflammatory episodes of SKs have promoted the appearance ofmalignant otitis externa, and it was also a cause of impaired hearing.

Histopathologically, SKs have characterizedfindings including acanthosis, papillomatosis,hyperkeratosis, horn cysts and horn pseudocysts.There are seven different histological subtypes:acanthotic, hyperkeratotic (also verrucous),adenoid, clonal bowenoid, irritated, andmelanoacanthoma[].The most common histologic type of SK in the ACE is reported as acanthotic [6].

Even though SKs are well known to be benign but the association of malignant neoplasms arising contiguous with or adjacent to these lesion has been previously is not exceptional [2].It should be considered when a lesion undergoes an unusual or abrupt change in size or color. In our report, there was an association of SKs with invasive Squamous cell carcinomas, but other association were reportedincluding in situ change (Bowen's disease), basal cell carcinoma, malignant melanomas, keratoacanthoma [2,7,8]

Kim and al found one on seven cases of SKs of ear, were associated with basal cell carcinoma [4].

Aetiologic factors that have been proposed to explain these exceedingly rare occurrences have included prolonged sun damage and chronic low dose radiation exposure. Also it was reported that this incidence is more higher in elderly patient with history of immunosuppression, particularly those had receive an organ transplant [8,9]

The treatment ofchoice in SKs is removal of the lesion using one of theavailable methods including curettage, cryotherapy, ablativelaser, use of topical vitamin D, and complete excision [4, 11]. For lesions in the ear canal, excision is the preferred therapy with histological examination of lesion. In malignant lesion, the treatment should be completed by cervical lymphadenectomy and radiotherapy according to stage of tumor.

Routine follow-up after the first treatment is essential, even ifthere will not have an association with malignant lesion on definitive histopathological examination, because SKs present a high risk of recurrence and possibility of malignant degeneration.

IV. Conclusion:

SKs of external auditory canal areextremelyrare. They occur in elderly and it often asymptomatic but it can cause hearing loss and repetitive otitis externa. An association with malignantskin tumorshas been reported, but rarely in external auditory canal.Cliniciansshould always be kept in mind forthis occurrence especially incase ofrefractory malignant otitis externaandhe should consider complete removal with histological examination.

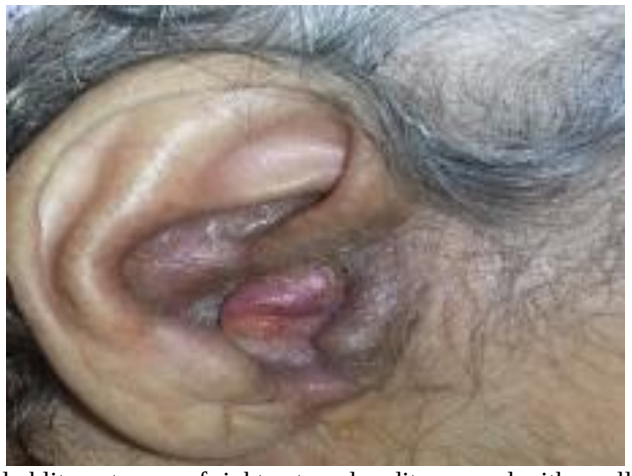

Figure 1: Inflammatory and obliterant mass of right external auditory canal with swelling and redness of concha

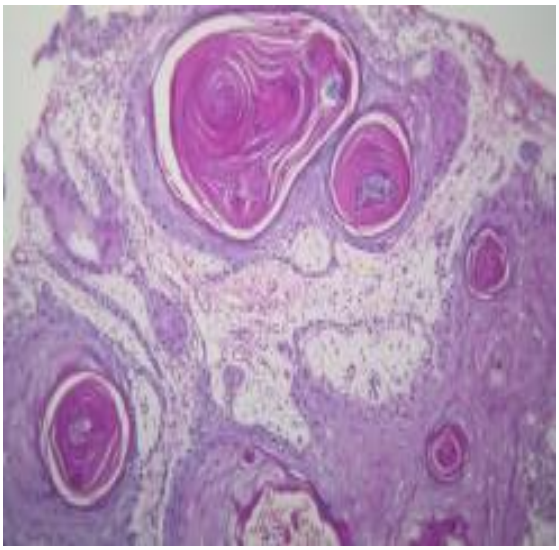

Figure 2: Histological appearance of Seborrheic keratosis: hyperkeratotic subtype, with papillomatosis, horn cysts and pseudocysts

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