

CASE REPORT

A RARE CASE OF CONFLUENT AND RETICULATE PAPILOMATOSIS

Priya J. Talageri¹, Mamatha P², Ashwini N³, Khushbu Tantia⁴, K. Hanumanthayya⁵

HOW TO CITE THIS ARTICLE:

Priya J. Talageri, Mamatha P, Ashwini N, Khushbu Tantia, K. Hanumanthayya. "A Rare Case of Confluent and Reticulate Papillomatosis". Journal of Evidence based Medicine and Healthcare; Volume 2, Issue 26, June 29, 2015; Page: 3962-3965.

ABSTRACT: Confluent and Reticulate Papillomatosis (CRP) or Gougerot Carteaud Syndrome, is a rare dermatosis of unknown etiology. A 27 year old female patient developed asymptomatic brown-hyperpigmented, flat topped warty papules and plaques on the upper back and intermammary area with a characteristic histopathology suggestive of confluent and reticulate papillomatosis. We are reporting a rare case of CRP, since very few cases have been reported from India.

KEYWORDS: Confluent and Reticulate Papillomatosis (CRP).

INTRODUCTION: Confluent and reticulate papillomatosis (CRP) or Gougerot Carteaud syndrome, is a rare, genetically determined defect of keratinization. It is characterized by persistent, asymptomatic, papulo- verrucous lesions of characteristic distribution, that have a tendency to become confluent and produce a reticulated pattern.⁽¹⁾ It is a rare dermatosis which is more frequently found in women, with higher incidence between the ages of 10 and 35 years.⁽²⁾

CASE REPORT: A 27 year old female patient presented to our OPD with asymptomatic hyperpigmented lesions over the upper back and intermammary area since one and a half year, these lesions appeared after second pregnancy. No history of similar complaints in family. No history of application of any topical medication prior to onset of lesions.

On dermatological examination lesions were multiple well defined brown, slightly elevated flat topped warty papules and plaques on the upper back and intermammary area, which were confluent in centre and reticulate at periphery. Microscopic examination of the scrapings with 10% KOH showed no fungal elements. There was no other systemic involvement.

Skin biopsy showed mild compact hyperkeratosis and acanthosis focally. Dermis showed papillomatosis projection. Skin adnexa are seen in superficial and deep dermis. Superficial dermis showed perivascular lymphocytic infiltration. This was suggestive of CRP.

DISCUSSION: The first case of this disorder was presented by two French dermatologists, Gougerot and Carteaud in 1927 under the name of papillomatoses pigmentee innominee. In 1932, they classified cutaneous papillomatoses into three groups.

- a. Punctate, pigmented and verrucose papillomatosis.
- b. Confluent and reticulated papillomatosis.
- c. Nummular and confluent papillomatosis.⁽²⁾

CASE REPORT

The term "reticulate" is commonly used for clinical description of "net-like", "sieve-like," or "chicken wire" configuration of the skin lesions. Various congenital and acquired dermatoses present with this pattern of skin lesions. Many systemic diseases also present with such cutaneous manifestations providing useful clues to diagnosis.⁽³⁾

CRP is an uncommon dermatosis that affects young individuals and eruption consists confluent, flat, red-brownish papules localized primarily to the intermammary and interscapular regions with subsequent spread to the breast and arms; at the periphery, the papules spread out forming a pigmented reticulated pattern. Disease begins on an average, in the late teens or early twenties, has an approximately equal sex distribution, and affects whites, blacks, and Asian patients.⁽⁴⁾

Many etiologies have been proposed. Proposed causes include obesity, disturbance of keratinization, and exposure to ultraviolet light, endocrine imbalance and infection with *Pityrosporum ovale* or abnormal host response to *Malassezia furfur*.⁽⁵⁾

Confluent and reticulate papillomatosis has variable clinical presentation.

The criteria for diagnosis are⁽⁶⁾:

- Hyperpigmented papules and plaques involving the chest and/or back with a reticulated peripheral margin.
- No hyphae suggestive of tinea versicolor present on potassium hydroxide preparation or skin biopsy.
- Histological changes including hyperkeratosis, papillomatosis, acanthosis alternating with mild atrophy, and evidence of mild dermal inflammation and vasodilation.

Confluent and reticulate papillomatosis is a rare disorder that is most often clinically confused with tinea versicolor, even when CRP presents in a typical fashion.⁽⁷⁾

There is no standard therapy for CRP, etiology of it remains unclear. Various treatments have been tried, and there have been some reports of CRP responding to antibiotics, especially in recent years. Minocycline has become the drug of choice for this idiopathic condition. The anti-inflammatory effects of Minocycline have been attributed to their ability to inhibit the migration of neutrophils, prevent release of reactive oxygen species, and inhibit matrix metalloproteinases. The response of CRP to these specific antibiotics may be related more to their anti-inflammatory properties than to antimicrobial effects.⁽⁴⁾

Oral fluconazole 150 mg per week for one month is also effective and also topical 1% clotrimazole cream. Various other treatment modalities which have been used are topical tretinoin, topical calcipotriol, oral etretinate and isotretinoin and various antibiotics like fusidic acid and erythromycin have been used.⁽²⁾

CONCLUSION: Very few cases have been reported from India. Most of the reported cases are in Negroes. Occurrence of CRP in members of the same family suggests that it is possibly an inherited disorder. As most cases are sporadic, it was suggested that there might be an inherited and an acquired form. Most cases reported were stocky and obese. CRP affects both sexes but two thirds of the patients are women.⁽¹⁾

CASE REPORT

We are reporting a rare case of CRP in a 27year old female patient. Our Patient was treated with oral Minocycline 100mg once daily for 3 weeks along with topical tretinoin 0. 025% and topical vitamin D analogues. Patient had good response after completion of therapy with significant cosmetic improvement.

REFERENCES:

1. Binitha M P, Nair V L, Lilly M, Gopinath T. Confluent and reticulate papillomatosis. Indian J Dermatol Venereol Leprol 1990; 56: 48-49.
2. Hari Krishna Kumar. Y, Srivalli P, Ramesh Babu A. A case of Confluent and Reticulate Papillomatosis of Gougerot and Carteau. Int J Clin Dermatol Res. 2013; 1(1): 1-3
3. Adya K A, Inamadar A C, Palit A. Reticulate Dermatoses. Indian J Dermatol 2014; 59: 3-14.
4. Yu TG, Cao Y, Yang XH, Deng D, Lan SH. Two cases of confluent and reticulated papillomatosis successfully treated with Chinese drug jianpizhiyang granula.Indian J Dermatol 2009; 54: 60-62.
5. Rao T N, Guruprasad P, Sowjanya CL, Nagasridevi I. Confluent and reticulated papillomatosis: Successful treatment with minocycline. Indian J Dermatol Venereol Leprol 2010; 76: 725-725.
6. Sardana K, Goel K, Chugh S. Reticulate pigmentary disorders. Indian J Dermatol Venereol Leprol 2013; 79: 17-29.
7. Natarajan S, Milne D, Jones AL, Goodfellow M, Perry J, Koerner RJ. Dietzia strain xL a newly described Actinomycete isolated from confluent and reticulated papillomatosis. British Journal of Dermatology 2005; 153: 825-827.



Fig. 1



Fig. 2

Fig. 1 & 2: Multiple warty brown papules and plaques, reticulate in appearance seen over upper back.

CASE REPORT



Fig. 3

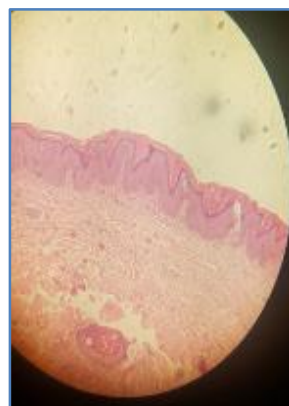


Fig. 4

Fig. 3: Clearance of lesions after 2 weeks of treatment.

Fig. 4: Biopsy showing, Mild compact hyperkeratosis and acanthosis focally. Dermis showed papillomatosis projection. Skin adnexa are seen in superficial and deep dermis. Superficial dermis showed perivascular lymphocytic infiltration. This was Suggestive of Confluent and Reticulate Papillomatosis.

AUTHORS:

1. Priya J. Talageri
2. Mamatha P.
3. Ashwini N.
4. Khushbu Tantia
5. K. Hanumanthayya

PARTICULARS OF CONTRIBUTORS:

1. Assistant Professor, Department of Dermatology, Vydehi Institute of Medical Sciences & Research Center, Bangalore.
2. Assistant Professor, Department of Dermatology, Vydehi Institute of Medical Sciences & Research Center, Bangalore.
3. Post Graduate Student, Department of Dermatology, Vydehi Institute of Medical Sciences & Research Center, Bangalore.

4. Post Graduate Student, Department of Dermatology, Vydehi Institute of Medical Sciences & Research Center, Bangalore.
5. Professor & HOD, Department of Dermatology, Vydehi Institute of Medical Sciences & Research Center, Bangalore.

NAME ADDRESS EMAIL ID OF THE CORRESPONDING AUTHOR:

Dr. Ashwini N,
Post Graduate Student,
Department of Dermatology,
Vydehi Institute of Medical Sciences & Research
Center, Bangalore-560066.
E-mail: ashwininarahari1239@gmail.com

Date of Submission: 23/06/2015.
Date of Peer Review: 24/06/2015.
Date of Acceptance: 26/06/2015.
Date of Publishing: 29/06/2015.