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Case Report

A case of confluent and reticulated papillomatosis of gougeret and carteaud

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ABSTRACT

Confluent and reticulated papillomatosis (CRP) of Gougerot and Carteaud, a rare skin disorder of unknown etiology, was first described in 1927. It is an uncommon but distinctive icthyosiform dermatosis seen in young adults. It is characterized by persistent brown, scaly macules, papules, patches and plaques, localized predominantly on the neck, intermammary, interscapular regions and axillae. There are numerous therapeutic options - topical retinoids and systemic retinoids, oral antibiotics but none are very effective. We report this case because of its rarity.

Keywords: Icthyosiform, Minocycline, Retinoids

INTRODUCTION

Gougerot-Carteaud syndrome or confluent and reticulated papillomatosis (CRP), was first described by Gougerot and Carteaud as dermatosis in 1927 and named this entity as papillomatosepigmenteeinnominee.[1] After 5 years, Wise and Sachs give the term confluent and reticulated papillomatosis.[2] CRP is an uncommon dermatosis that affects young individuals and consists of 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.[3]

Histopathological examination is not very characteristic and there are subtle affections, correlated with clinical presentation of hyperkeratosis, normally orthokeratotic, irregular papillomatosis, acanthosis predominantly in interpapillary areas and hypogranulosis. There may also be focal atrophy of stratum spinosum, hyperpigmentation of basal layer, without affection to number of melanocytes. In the dermis, there may be chromatophores on the papillary region, discreet mononuclear superficial perivascular infiltrate, mild ectasis of vessels, and small to moderate papillary edema.[4-8] The histopathological differential diagnoses include acanthosis nigricans, variants of seborrheic keratosis, non-inflammation epidermal nevus, Dowling-Degos disease and Becker nevus.[6]

CASE REPORT

A 23 year old man, presented with multiple hyperpigmented raised lesions over upper part of chest from 5 years. There was no itching, pain or tenderness. Number of lesions increased gradually and spread to involve lower part of neck (Figure 1). On examination, tan brown, pigmented multiple fine scaly papules and plaques were present on chest and anterior part of lower one-third of neck. Lesions were confluent in the center

and reticulate at the periphery.10% KOH wet mount test from scrapings was negative for fungal hyphae. Biopsy showed a sparse superficial perivascular lymphohistiocytic infiltrate with moderate epidermal hyperplasia. The granular layer was thickened and the stratum corneum showed mild compact lammelated orthohyperkeratosis with mild papillomatosis (Figure 2). We prescribed oral minocycline 100 mg daily and patient is on follow-up.

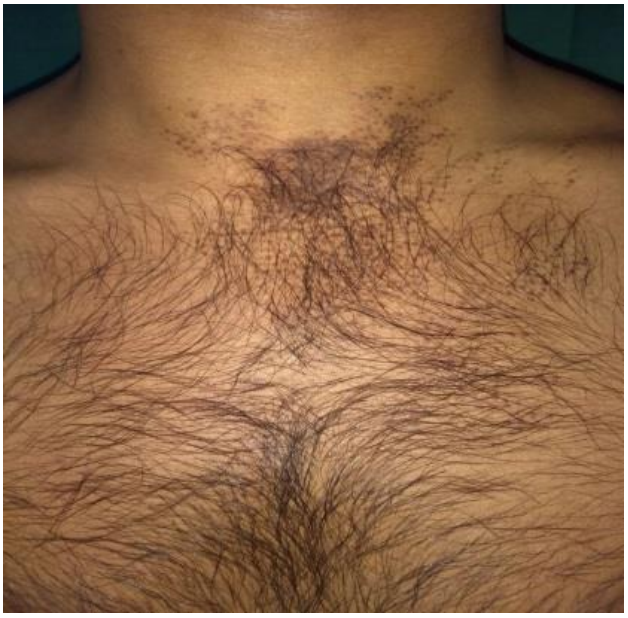

Figure 1: Photograph showing small, brown, scaly macules on anterior aspect of chest and neck.

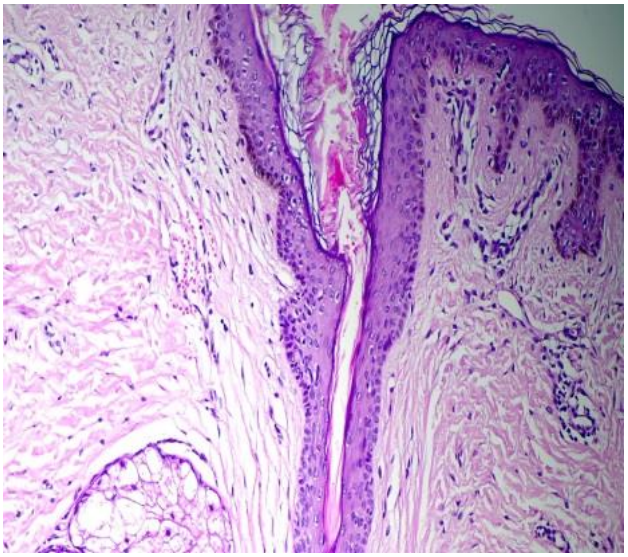

Figure 2: Photomicrograph of histopathology image (H & E stain X100) showing sparse superficial perivascular lymphohistiocytic infiltrate with moderate epidermal hyperplasia.

The granular layer was thickened and the stratum corneum showed mild compact lammelated orthohyperkeratosis with mild papillomatosis.

DISCUSSION

CRP is a rare skin condition; its etiology and pathogenesis are still poorly understood. The majority of CRP cases were sporadic, although familial occurrences have been reported. There is no standard therapy for CRP. Various treatments have been tried, and there have been some reports of CRP responding to antibiotics, especially in recent years and 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.[9] In the largest prospective cohort of eleven patients with CRP treated with oral minocycline 50 mg twice a day for 6 weeks with a mean follow-up period of 11 months, nine subjects had close to complete clinical resolution.[10] However, minocycline is not recommended in pregnancy (US Food and Drug Administration Category D). Oral clarithromycin at 500 mg once a day for 5 weeks and erythromycin 1,000 mg daily for 6 weeks have also been reported to be effective. Systemic retinoids are typically reserved for nonresponders to antibiotics. The prognosis of CRP is good with marked response (>50% improvement) when minocycline or azithromycin is used as first-line treatment.

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