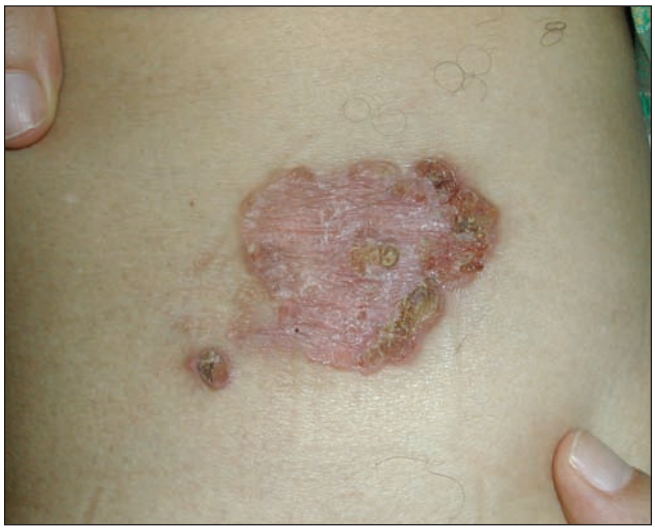
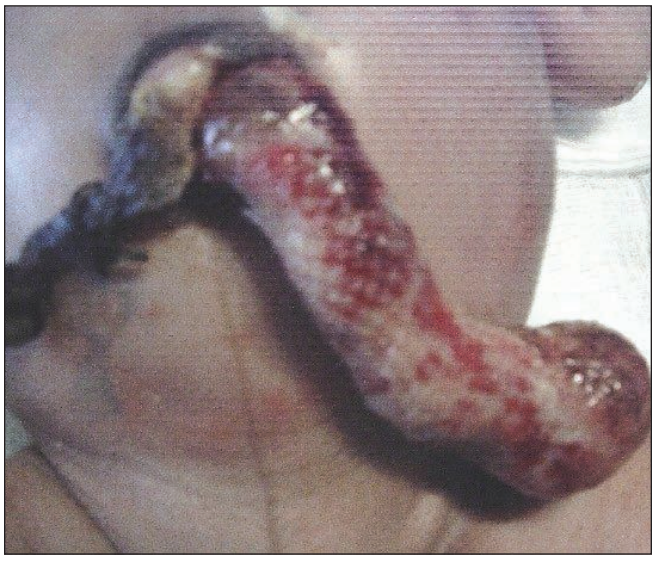
Clinical Vistas Briefs

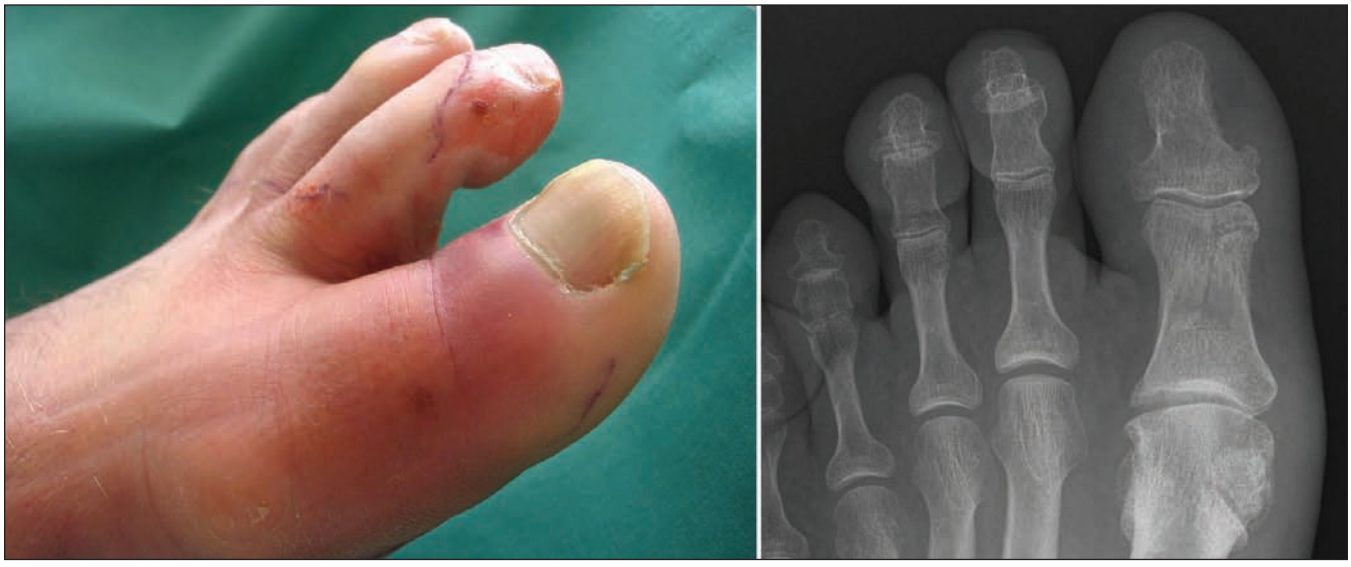
What's your call?



A 70-year-old otherwise healthy man presented with a 1-year history of these 2 gradually enlarging asymptomatic lesions over the right thigh.



Drum-stick–like congenital lesion measuring 20 × 2 × 8 cm in the umbilical region of an asymptomatic 5-day-old boy born at term.



A 50-year-old man with a history of gout presented with a tender, swollen, red great toe of 2 weeks' duration.

See page 740 for diagnoses.

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Bowen disease

Bowen disease is most commonly found in white patients over 60 years old. Other risk factors include chronic sun exposure, immunosuppression, arsenic exposure and cutaneous human papillomavirus (HPV) infection. HPV types 16, 18, 34 and 48 cause Bowen disease at genital sites; the role of HPV in nongenital cases of Bowen disease is less well defined. HPV types 2, 16, 34 and 35 have been rarely identified within nongenital lesions.

The lesions occur on mucous or cutaneous surfaces exposed to the sun (hands, head, neck) as a solitary, asymptomatic, sharply demarcated, scaly and erythematous plaque, measuring from a few millimetres to several centimetres in diameter (Fig. 1). The lesions may be fissured or verrucous or, rarely, pigmented. Ulceration may occur and is often a sign that invasive disease is developing. The lesion extends progressively in an annular or polycyclic pattern. The risk of progression of Bowen disease to invasive carcinoma is about 3%.[1]

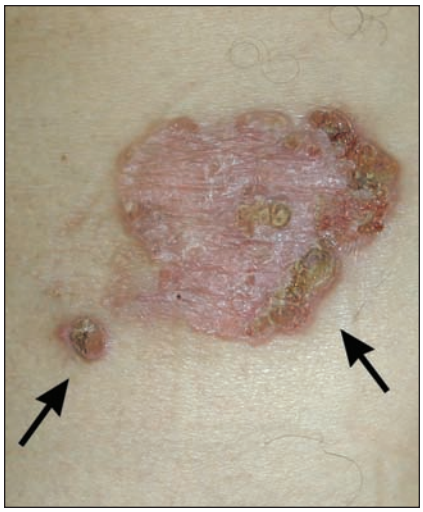

Fig. 1: The 2 lesions (arrows) with their well-defined and erythematous areas, and central and peripheral crusts and erosions were biopsied. Histology (images are available online at www.cmaj.ca/cgi/content/full/175/7/739/DC1) demonstrated changes consistent with squamous cell carcinoma in situ, or Bowen disease, with no dermal invasion.

The differential diagnosis includes superficial basal cell carcinoma, psoriasis and eczema, which can be differentiated histopathologically.

Treatment options are broad and include surgical excision, curettage and electrodessication, cryotherapy, topical administration of 5-fluorouracil, imiquimod, photodynamic therapy and CO_2 laser therapy. The choice of treatment depends on the size, location and accessibility of these therapies.

Nadia Akhdari
Said Amal
Department of Dermatology
Salwa Ettalbi
Department of Plastic Surgery
MedVI University Hospital
Guéliz, Marrakech
Morocco

REFERENCE

1. Cox NH, Eedy DJ, Morton CA. Guidelines for management of Bowen's disease. *Br J Dermatol* 1999; 141:633-41.

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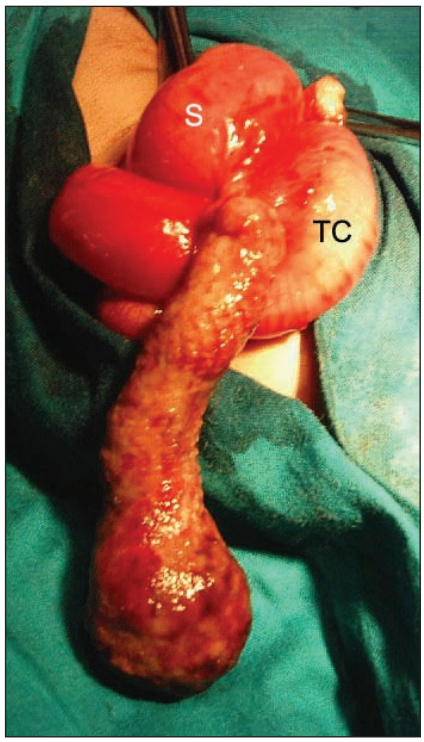
Gastroenteric duplication cyst

The child was born in a rural hospital in Nigeria. His mother had an unremarkable pregnancy and normal vaginal delivery. She was well and reported taking only routine prenatal vitamins with folic acid and supplements of iron and vitamin B complex. There was no family history of congenital malformations. No antenatal ultrasonography was done during the pregnancy.

The mass was present since birth. The boy was ultimately brought to our children's emergency department at 5 days of age for assessment. His parents were uneducated and very poor, which probably accounted for the delay in their following up the referral for surgical consultation. The boy was otherwise well, in no distress, with an unremarkable examination except for the umbilical hernial mass. The mass protruded from the umbilical ring to the left of the umbilical stump. A provisional diagnosis of gastroschisis was made.



Intraoperatively, however, the mass was noted to have no connections to the stomach, transverse colon or umbilical ring. Instead, it was found to arise from the omentum between the greater curvature of the stomach (S) and the transverse colon (TC) (Fig. 1). The mass was excised and was found to contain a thick, gelatinous, greenish-yellow substance (see Appendix 1, available online at www.cmaj.ca/cgi/content/full/175/7/739-a/DC1). Histopathology confirmed smooth-muscle lining of the cyst wall and mucinous glands (see Appendix 2, available at www.cmaj.ca/cgi/content/full/175/7/739-a/DC1). A gastroenteric duplication cyst was confirmed. The child did well postoperatively.

Gastroenteric duplication cysts are rare malformations that vary in location, size, appearance and symptoms. Although recognized since 1733, it was not until 1937 that Ladd[1] intro-