

What Is Your Diagnosis?



A 51-year-old obese man presented to our clinic with a slowly progressive, papillomatous plaque covering a large portion of his back. He initially reported the eruption along the upper back 9 years prior to presentation but had noted a recent insidious progression to involve the majority of the back. The rash was slightly tender; he denied other symptoms including fever, chills, or drainage. Physical examination was notable for a large hyperkeratotic plaque with central pink, friable, papillomatous papules and nodules covering the majority of the back (left). Along the upper shoulder and neck (right) there was a well-defined, erythematous, indurated plaque with a sharp delineation from the surrounding uninvolved skin. A wedge biopsy from the central papillomatous portion of the back and a punch biopsy from the erythematous indurated leading edge of the plaque both revealed lymphangiectasia and epidermal hyperplasia.

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The authors report no conflict of interest.

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The Diagnosis: Elephantiasis Nostras Verrucosa of the Back



Within a week after his initial presentation, our patient was hospitalized with cellulitis around the affected area of his back. Tenderness and erythema improved with antibiotics. Since his initial presentation, he had been maintained on prophylactic double-strength trimethoprim-sulfamethoxazole (160 mg/800 mg) 3 times a week for more than 1 year without any repeat episodes of cellulitis. He experienced a reduction in the overall size of the affected area and was considering a weight-loss program to help reduce the extent of the lymphedema.

Elephantiasis nostras verrucosa (ENV) is a condition defined by hyperkeratosis and papillomatosis of the epidermis overlying an indurated fibrotic dermis.¹ The underlying concern in ENV is chronic lymphedema. Elephantiasis nostras verrucosa generally occurs in dependent areas, such as the lower extremities, but there are isolated reports of ENV affecting the buttocks, ears, and panniculus.²⁻⁵ We report a novel presentation of ENV of the back.

Regardless of its location, ENV is difficult to treat. Compression therapy is standard in most cases. However, this approach is unpractical when ENV affects certain areas, as in our patient. Perhaps the most important aspect in managing our patient's lymphedema was to prevent bacterial superinfection.

Lymphedematous tissue can serve as a nidus of infection. Recurrent episodes of cellulitis and lymphangitis can exacerbate the extent of lymphedema. Our patient was hospitalized with cellulitis within a week after his initial presentation; after being discharged, he was treated with a prophylactic dose of trimethoprim-sulfamethoxazole without any repeat episodes of cellulitis or lymphangitis.

Our patient presented with ENV in an unusual location. As with other cases of ENV, the response to therapy has been suboptimal. We had hoped to reduce lymphedema with weight reduction and prevention of secondary infections. Unfortunately, our patient was lost to follow-up.

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