Bowen's disease – A skin lesion to look out for in surgical clinics

Alok Vardhan Mathur · J. S. Bist · Sandip Kudesia · Manish Anand

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A 62 year-old-male patient presented to our hospital with a skin lesion on his right upper thigh for the last 1 year. It had been progressively increasing in size and was associated with local itching. General examination was unremarkable and local examination showed a 5 cm by 5 cm well demarcated elevated papule (Fig. 1). There was no local or regional lymphadenopathy. A clinical diagnosis of BD was made which was confirmed on histopathology. A wide excision of the lesion with an margin of 0.5 cm all around was carried out. Microscopic examination showed the entire neoplastic process confined to the epidermis with an intact basement membrane and no dermal invasion. Many cells appeared highly atypical showing hyperchromatic nuclei with frequent irregular mitosis (Fig. 2).

BD should be suspected clinically on the presence of an elevated scaly pink or erythematous patch, with irregular borders, which may itch or ooze or crust and may be mistaken for rashes, eczema, fungal infection or psoriasis.

The lesions may occur anywhere on the skin surface or on mucosal surfaces, although involvement of palms or soles is uncommon. BD occurs predominantly in women (70–85% of cases); about three-quarters of patients have lesions on the lower leg (60–85%), usually in sun-exposed areas of skin. Solar damage, trivalent arsenic compounds, immune suppression, Human papilloma virus infection, chronic skin inflammation and dermatosis have been implicated as etiologic factors.

A. V. Mathur¹ · J. S. Bist² · S. Kudesia³ · M. Anand¹

¹Department of Surgery,

²Department of Dermatology,

³Department of Pathology,
Shri Mahant Indires Hospital,
Patel Nagar, Dehradun, India

A. V. Mathur (✉)

E-mail: dralokvardhanmathur@yahoo.com

Fig. 1 Close up photograph showing well defined elevated papular erythematous lesions with surface crusting and scaling

Fig. 2 Photomicrograph showing irregularly thickened epidermis exhibiting cellular disarray in the entire layer. Cells appear highly atypical with large hyperchromatic nuclei and show numerous atypical mitosis (arrows) H and E $\times$ 400

The most common treatment of intraepidermal SCC *in situ* is surgical excision. The standard practice is to remove about half a cm beyond the edge of the lesion. In a small percentage of cases, an invasive SCC develops. For

this reason, all patients with BD should remain under follow up. To avoid missing an invasive lesion, it is advisable to microscopically examine representative sections throughout the entire tissue block.