Case Report

KELOID DISEASE – A CASE REPORT

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Abstract

The keloid is a sharply, elevated, irregularly, shaped progressively enlarging scar due to excessive collagen formation in the dermis during connective tissue repair following some inciting factors like trauma, itching and scratches. Some genetic, racial and environmental factors are also found to be associated with keloid formation. Histological features include cellular fibrous band in the upper reticular dermis and prominent fascia- like band composed mainly of either type -3 (early) or type -1 (late) collagen. In most of the cases it has distinctive anatomical locations. We report a case of excessive keloid formation in a 35 Yrs old female following itching in which no other etiology could be found after detailed history, examination and investigation. Because of the rapid and extensive nature of the disease it is a matter of further research.

Keywords: Keloid, Hypertrophic scar

Case Presentation

A 35 years old woman presented with multiple extensive, painless, pink/brown coloured, firm, irregular scars over pre sternal and parasternal region, both breasts, lower abdomen, back and both arms.¹² The chief complaint of the patient was ugly looking appearance which had an effect over her personal life.¹ The evolution of disease was gradually progressive over the course of six months following itching at pre sternal region. There was no history of trauma, insect bite or any drug reactions. No history of any chronic disease like diabetes and hypertension. The lady was a nonsmoker, housewife and from a low socioeconomic strata. The patient denied a positive family history of keloid formation or any history of viral, autoimmune or other related pathological entity. The clinical differential diagnosis considered were keloid, Lobomycosis, Keloid morphea and Granuloma fasciale. The patient was managed for prominent keloid over breast area and intralesional administration of triamcinolone 40 mg/ml followed by silicone sheath application and customized pressure garments.² Intralesional steroid injection repeated after 15 days. A total of three cycles were given. The lesions showed significant improvement.

Discussion

Keloids are known to occur following epithelial breach. Dark skin people are more likely to develop hypertrophied scar. Certain anatomical sights like sternum and parasternum area more likely to develop Keloid. Severity of trauma, loss of tissue, contaminated wounds are more likely to heal with keloid formation. Relaxed suture line and clean wounds have less tendency for
hypertrophy. Multilayer closer of wound provide relaxed suture line and so less tendency for hypertrophy. Pressure areas are at a constant risk for trauma and heal with hypertrophy. People having keloid formation tendency wearing prophylactic pressure garments have prevented keloid formation. Studies demonstrated that keloids contain an increased level of immunoglobulins suggesting that they may be produced by an abnormal immune reaction. Systematic therapy for this type of extensive Idiopathic Keloid disease is still an illusion. In vitro studies showing that fibroblasts when cultured with keloid keratinocytes suggest that keloid may be a result of abnormal epithelial-mesenchymal interactions.

In future the approach to Keloid scarring will be to undertake a biomolecular characterization of scar and individualizing the treatment. The use of stem cell culture is a step ahead in the treatment for Keloid. In the present case the disease was very extensive involving whole of trunk and back.

In our patient, conservative management was implemented which include hygienic relief, washing, drying and intraläsional corticosteroids and continuous pressure which gave continually progressive acceptable results. Till date there is no definite prophylactic therapy, or systemic therapy for keloid to cure this deformity. Histopathological and biochemical mechanism of keloid formation has shown a way for immunosuppressive drugs in these extensive keloid disease.

References


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