Sclerotic Fibroma: A Differential Diagnosis of Spontaneous Keloid

Fibroma Esclerosante: Um Diagnóstico Diferencial de Queloide Espontâneo

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CASE DESCRIPTION

Sclerotic fibroma (SF) is a rare neoplasm first described in 1972 by Weary et al in association with Cowden syndrome.¹ This rare syndrome typically manifests with mucocutaneous findings (trichilemmomas, verrucous papules in the oral mucosa, acral keratosis and sclerotic fibromas) and an increased risk for several neoplasms.¹ Later, Rapini e Golitz coined the term solitary SF in the absence of Cowden syndrome.² It is debatable whether SF is distinct lesion or a sclerotic evolutionary end-point of other conditions.³

SF manifests clinically as an asymptomatic, well-demarcated skin-colored to erythematous papule or nodule with no site or sex predilection.²,³ The authors present a healthy 56-year-old male with a pink, linear plaque located on the left shoulder slowly growing for about 20 years. He was previously treated with intralesional corticosteroids for a suspected spontaneous keloid but the patient abandoned treatment by his own initiative.

Physical examination revealed a firm, well demarcated, pink plaque measuring 15 x 2 cm (Fig. 1). The distal part of the plaque had a digitiform, infiltrative border (Fig. 2). A skin biopsy revealed a well-circumscribed, non-encapsulated dermal nodule and hypocellular aggregation of collagen bundles in the mid dermis separated by distinctive clefts ("plywood-like" pattern). These findings are characteristic of SF.⁴

The patient denied any kind of local trauma, family history was unremarkable and there were not any other criteria of Cowden’s syndrome.

Cryosurgery was initiated with partial regression in the 6-month follow-up.

This case has some unique particularities: the atypical keloid-like presentation and the remarkably wide dimensions and continuous growth which, in our perspec-
tive, supports the hypothesis of SF as true neoplasm. We recommend that SF should be included in the differential diagnosis of spontaneous keloids. No treatment is usually necessary but due to the necessity of histologic confirmation, surgical recession is the standard treatment.\(^5\) In our opinion however, cryosurgery seems to be an effective alternative.

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**REFERENCES**


