Carcinoma of the penis developing in lichen sclerosus et atrophicus

J. S. BINGHAM
From the Department of Genitourinary Medicine, Middlesex Hospital, London

SUMMARY Malignant change developing in lichen sclerosus et atrophicus is rare in men. A case is described in a 39-year-old man.

Introduction

Lichen sclerosus et atrophicus (LSA) is an uncommon disease of unknown aetiology in which small, white areas on the skin may be associated with an atrophic condition of the vulva, perianal skin, and penis. It was first described by Hallopeau in 1887, and Darier reported the histological changes in 1892.

It occurs more commonly in women than in men, and its reported incidence in a general hospital varies from 1/300 to 1/1000 depending on the liaison between the dermatology and gynaecology departments (Wallace, 1971).

Montgomery (1941) found that the mean age for the onset of LSA in women was 50 years and in men 40 years. The mean age of 11 men seen at the Department of Genitourinary Medicine, Middlesex Hospital, since 1966, was 29.4 years. Indeed Wallace (1971) found that 30 out of 44 cases in men occurred between the ages of 15 and 45 years. Of his 44 patients only two developed carcinoma of the penis, one aged 48 and the other 58; this gives the impression that this is a rare development and that it tends to occur in men in an older age group. The aim of this report is to describe malignant change in a younger man with LSA of the penis.

Material and methods

CASE REPORT

The patient, a 39-year-old Caucasian married garage proprietor, presented with a four-month history of a 'sore' on the glans penis which caused discomfort and was aggravated by sexual inter-
Carcinoma of the penis developing in lichen sclerosus et atrophicus

**FURTHER INVESTIGATIONS AND SUBSEQUENT MANAGEMENT**

Chest x-ray examination showed no abnormality. A lymphangiogram showed no evidence of either inguinal or pelvic lymph node involvement. Haemoglobin was 15.7g/100ml (15.7 g/dl); white cell count was 9.2×10³/mm³ (9.2×10³/l); and the other blood indices were within normal limits. Serum cholesterol, bilirubin, alkaline phosphatase, aspartate transaminase, total protein, albumin, calcium, sodium, potassium, chloride, phosphate, and urea levels were all normal.

The patient was treated with electron therapy by means of a linear accelerator; a total of 4200 rads was administered over three weeks, and he is well 17 months after treatment.

**Discussion**

The patient had some of the characteristic features of LSA, namely, the classical clinical appearance and a history of acquired phimosis. Lesions can also occur on the shaft of the penis but did not do so in this case. LSA never appears on the scrotum (Wallace, 1971), which is interesting as the derivation of the scrotum is similar to that of the vulva.

This case is reported because carcinoma developed at the early age of 39 in a man in whom LSA had probably been present for at least seven years, that is, since the circumcision for acquired phimosis. Histological examination was not carried out, and it has been suggested that the diagnosis can be overlooked if this is not undertaken (Fairgrieve, 1959).

Carcinoma of the penis developing in LSA has been described by several authors (Stühmer, 1928; Frühwald, 1935; Grütz, 1937). In women carcinoma of the vulva usually develops in a leucoplakic area, but while leucoplakia coexists in about 50% of cases in women (Wallace and Whimpster, 1951) it is rarely seen in men and was not present in this case. Hart et al. (1975) studied 107 patients with LSA of the vulva and found coexisting, invasive carcinoma in only five cases. Careful histological examination showed no evidence that the carcinoma actually arose from areas of LSA. In this case, although there was no histological confirmation of LSA in the biopsy specimen, as the lesion was not widely excised, the carcinoma did appear macroscopically to be in the centre of an area of LSA.

The ulcerated area was treated initially with fluorocinolone cream, but it has been recommended (Rook et al., 1972) that stronger fluorinated corticosteroids should not be used, particularly if fissures or superficial ulcers are present.

It was decided not to amputate the penis as a method of treatment on account of the young age of the patient. The possibility of using cobalt needle insertion was also discounted because of the small size of the penis.

Survival-rate figures vary, but de Kernion et al. (1973) found, in carcinoma arising de novo, a three-year survival rate of 96% with stage I lesions (the stage in this case), and von Alth et al. (1973) found a five-year survival rate of 84% at the same stage.

I would like to thank Dr R. D. Catterall, Dr R. H. Meara, and Dr A. Jeliffe for their assistance in the management of this case.

**References**


Carcinoma of the penis developed in lichen sclerosus et atrophicus.

J S Bingham

Br J Vener Dis 1978 54: 350-351
doi: 10.1136/sti.54.5.350

Updated information and services can be found at:
http://sti.bmj.com/content/54/5/350

These include:

Email alerting service
Receive free email alerts when new articles cite this article. Sign up in the box at the top right corner of the online article.

Notes

To request permissions go to:
http://group.bmj.com/group/rights-licensing/permissions

To order reprints go to:
http://journals.bmj.com/cgi/reprintform

To subscribe to BMJ go to:
http://group.bmj.com/subscribe/