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Chief Complaint

Exertional dyspnea for two months, recent admission for the same

History of Present Illness

A 90-year-old male with medical history of Prostate Cancer status post radiation therapy (10 years ago), COPD, Atrial Fibrillation, AAA, CVA, CAD, HTN, HLD, and recent admission for acute decompensated heart failure presents to the emergency department for shortness of breath. The patient was discharged 1 week ago "still not feeling 100%." He went for clinic follow-up where he reported feeling "short of breath," and was directed to the emergency department. He denies fevers, chills, diffuse body aches, chest pain, cough, sputum production, wheezes, stridor, nausea, vomiting, lightheadedness, or loss of consciousness. Additionally, he denies any constipation, diarrhea, night sweats, or knowledge of any rashes skin lesions, especially any on his back, which he reports not having viewed in many years. However, he does report unexplained weight loss.

Pertinent Physical Exam

T: 36.0 °C HR: 87 RR: 18 BP: 136/100 SpO2: 99%

Constitutional: cachectic, nontoxic-appearing elderly male upright in gurney wearing hospital gown
Cardiovascular: irregular rhythm, no audible murmurs, distal pulses intact in all 4 extremities, no peripheral edema, no JVD

Respiratory: mild rales greater right than left, equal chest rise/fall, nonlabored respirations

Skin: intact, dry, warm, acyanotic, fingernails dull pink with capillary refill <2sec, no clubbing,, diffuse raised immobile dark-brown plaque lesions of the back that are nontender and varying in size, no bullae or blistering

Lymphatics: no preauricular/cervical/supraclavicular lymphadenopathy

Results

VBG 7.40/ 45/30/37

WBC 10.7

H/H 15.7/47

K 3.2

Ca 10.1

Procalcitonin 0.09

SARS-CoV2 (-)

Troponin (-), BNP 4004 (baseline 9000)

CXR Impression:

Right upper lobe opacities with small bilateral pleural effusions. These are not changed from earlier and represent resolving edema.



Answers

1. Seborrheic Keratosis(es)
2. Sign of Leser-Trélat; this may indicate underlying malignancy, especially gastrointestinal malignancies

Case Discussion

This 90-year-old male with known medical history of previous prostate carcinoma status post radiation one decade ago (no longer followed by Urology) and recent admission for decompensated heart failure presented to the ED with lingering heart failure symptoms. He likewise answers affirmatively to having had experienced recent unexplained weight loss, and he appears cachectic. He was given an intravenous administration of his home dose of Lasix before being discharged after resultant symptomatic abatement. However, during his workup, numerous previously unrecognized seborrheic keratoses were noted to be located on the patient's back, consistent with the Sign of Leser-Trélat. An electronic message was sent directly to the patient's PCP to raise awareness and recommend assurance that the patient is followed up for renewal of cancer screenings, especially given his history of prostate cancer.

Pearls

- Recognizing and identifying issues that warrant outpatient, non-emergent workup from a primary care provider is an important ED task as ED visits continue to increase annually across the country. It is appropriate for the Emergency Physician to defer these issues to patients' PCPs to ensure adequate workup and follow up.
- Seborrheic keratoses, when isolated, are almost always benign skin lesions in patients greater than 40 years of age. In contrast, the Sign of Leser-Trélat, an abrupt eruption of multiple seborrheic keratoses, can be a paraneoplastic marker of underlying malignancy, most commonly gastric/colon/rectal adenocarcinomas with gastric adenocarcinoma being the most common.
- Physical examination will typically reveal numerous seborrheic keratoses, usually on the patient's back, that may be symmetric and resembling a "Christmas tree," "splash," or "raindrop" pattern. Pathophysiology of the sign is unknown.
- Screening for underlying neoplasm should include thorough history and physical exam in addition to CBC, CMP, gender-specific cancer screenings, chest x-ray, and especially upper and lower endoscopies.
- The sign will involute in roughly 50% of patients in which the underlying malignancy is appropriately managed.

Questions

1. The skin lesions depicted on the patient's back are incidentally noted and unrelated to the original complaint that brought the patient in to the ED. What skin lesions are they?
2. When these lesions crop up in this location, what is this phenomenon (sign) known as, and what underlying condition(s) may it indicate?

Disclaimer

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References

1. Bernett CN, Schmieder GJ. Leser Trelat Sign. [Updated 2020 Sep 3]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2021 Jan. Available from: <https://www.ncbi.nlm.nih.gov/books/NBK470554/?report=classic>
2. Chakradeo K, Narsinghpura K, Ekladios A. Sign of Leser-Trélat. BMJ Case Rep. 2016;2016:bcr2016215316. doi:10.1136/bcr-2016-215316
3. Sardon C, Dempsey T. The Leser-Trélat sign. Cleve Clin J Med. 2017;84(12):918-918. doi:10.3949/ccjm.84a.17021
4. Asri H, Soualhi M. The sign of Leser-trélat: Think in the adenocarcinoma of the lung. Pan Afr Med J. 2018;30:8688. doi:10.11604/pamj.2018.30.270.16337
5. Wagner Jr RF, Wagner KD. Malignant Neoplasms and the Leser-Trélat Sign. Arch Dermatol. 1981;117(9):598-599. doi:10.1001/archderm.1981.01650090080036