Giant sebaceous horn
I Wani1, S Rasool1, S Mushtaq1, S Firdous1, H Jaweed1, M Nazki1, J Wani1

Abstract
Introduction
Giant sebaceous horn is rare. A case of giant sebaceous horn on the ear is presented.

Case report
Presentation was as a painless swelling. Treatment was surgical excision.

Conclusion
Giant cutaneous horns are rare. These are slow to grow. Excision biopsy is the treatment of choice.

Introduction
Cutaneous horn or cornu curtaneum is a keratotic mass arising from the cutis. These are usually asymptomatic, slow growing, of variable size and resemble a miniature horn. Cutaneous horn is more common in the upper areas of the face and next to the external ear. This can occur in association with, or as a response to a wide variety of underlying benign, pre-malignant, and malignant cutaneous diseases. Excision with histopathology is the treatment of choice. Occurrence on the ear of a giant sebaceous horn is rare. This paper reports a case of a giant sebaceous horn on the ear.

Case report
A 70 year old man presented with painless curved swelling on the back of the left ear for 6 years. These have no direct links with the presentation. Painful itch, bleeding or discharge from the base of the lesions is more relevant. General physical and systemic examinations were normal. Local examination revealed a hard curved growth on the back of the left ear, free from underlying structures measuring about 16 cm in length and about 3.5 cm wide at the base (Figure 1). There were few actinic keratotic patches present on the neck and ear.

There was no regional lymphadenopathy. A clinical diagnosis of cutaneous horn was made. Wide local excision of the swelling was done (Figure 2).

Histopathology of specimen was consistent with diagnosis of actinic keratosis. Follow up period was uneventful for the last 2 years.

Discussion
Cutaneous horns are rare skin lesions caused by overgrowth of the most superficial layer of skin. Occurrence of the cutaneous horn is seen in people 50 years or older and with no sexual predilection. The distribution of the cutaneous horn is usually in sun-exposed areas, particularly the face, pinna, nose, forearms, and dorsum of the hands. They grow slowly over years to decades, but sometimes rapid growth may occur. Mostly they are solitary. They are variable in shape, size and colour. Most have a yellow-white colour. Size varies from a few millimetres to several centimetres in length. A cutaneous horn can be cylindrical, conical, pointed, corrugated transversely and longitudinally, or curved and the base of the cutaneous horn may be flat, nodular, or crateriform. This hyperkeratotic papule has a height greater than one-half the width of the base. Because of their excessive height, they can be traumatized. This may result in inflammation at the base with resulting pain.

A cutaneous horn is a clinical diagnosis and considered a reaction pattern of the skin. Aetiology is unknown. This has been commonly seen in light skinned people with exposure to sunlight acting as trigger. They are thought to result from underlying benign, premalignant or malignant pathology, in 61.1%, 23.2% and 15.7% of cases respectively. Risk factors for underlying malignancy include advanced age, male sex when compared with age-matched women, large base or height-to-base ratio, and presence on a sun-exposed location.

The lesion at the base of the keratin mound is benign in the majority of cases. Surrounding inflammation and an infiltrated base are unusual, but they may indicate malignancy. Tenderness at the base favours malignancy and is often a clue to the presence of a possible underlying squamous cell carcinoma, being the most common type of associated malignancy. Others have reported cutaneous horns arising from burn scar, or HPV-2 subtype cutaneous infection. Cutaneous horns have been reported very rarely in association with soft-tissue neoplasms, metastatic renal cell carcinoma, lymphoma, dermatofibroma, and pyogenic granuloma. Excision biopsy was done.
Conclusion
Giant cutaneous horns are rare. These are slow to grow. Excision biopsy is the treatment of choice.

Consent
Written informed consent was obtained from the patient for publication of this case report and accompanying images. A copy of the written consent is available for review by the Editor-in-Chief of this journal.

References
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