Giants Keloids of the face: Report of two cases

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Abstract
Keloids are benign unsightly cutaneous tumors relatively frequent in dark skin. Among rare patients, they can take a particularly significant size with repercussions on the daily activities and the quality of life. The choice of the treatment protocol to restore the esthetics of the face and to avoid the recurrences constitutes a true challenge especially in a context of limitation of resources.

Objective: The aim of this study was to present giants keloids of the chin and the ear and their management in our context.

Cases presentation: Case 1: A 25 year’s old young woman was received five years after ear piercing, with an exuberant keloid of the right ear, of 30 × 14 cm, treated by immediate wound closure after removal. Intrallesional corticosteroid injection was performed every three weeks. The patient showed no recurrence after 12 weeks.

Case 2: The second patient was a man, 44 years old, farmer, traditionally scarified, living more than 200 kilometers to our town, received a barbae pseudofolliculitis with keloid infected, festering responsible of the marginalization of the patient, evolving more than 10 years. The size of the keloid tumor was 12 centimeters broad, covering the entire chin and extended to the cheeks. The treatment consisted first seven days of local care, followed by surgical removal and finally after 10 days of local care, a skin graft was taken from thighs of the patient. Corticosteroid was injected in the wound every three weeks. The patient showed after 15 weeks hypertrophic scars of the boundaries which remained 5 months later.

Conclusion: Surgical removal is for us the first treatment of giants keloids. The intrallesional injection of corticosteroid after surgery seems to move back the time of keloid recurrence; however their prevention still remains a great challenge in our context.

Keywords: Giant keloid; Face; Treatment

Introduction
Keloids are benign unsightly cutaneous tumors relatively frequent in dark skin. Among rare patients, they can take a particularly significant size with repercussions on the daily activities and the quality of life. The choice of the treatment protocol to restore the esthetics of the face and to avoid the recurrences constitutes a true challenge especially in a context of limitation of the resources.

Cases Presentation
Case 1
A 25 years old young woman, housewife, living in a village distant of about 100 kilometers to our hospital, was received an exuberant keloid of the right auricle five years after ear piercing, and ulcerated by places. The size of the ear tumor was 30 centimeters in its greater diameter and 14 centimeters broad (Figure 1). Elsewhere she had keloid on the external face of her right arm. The treatment consisted of local care of the ear keloid in 7 days, followed by surgical removal under general anesthesia. In the same time, we removed the keloid of the arm. The wound was immediately closed with 3/0 interrupted monofilament sutures.

Figure 1: Giant keloid of the right auricle of patient 1(a), the same patient after surgery (b).

After closure of the skin, 80 mg of triamcinolone was injected into the wound and a dressing applied. The sutures were removed after 10 days and triamcinolone was continued, every three weeks. The patient showed no recurrence after 12 weeks and did not come back for the follow up.

Case 2
The second patient was a man, 44 years old, farmer, traditionally scarified, living more than 200 kilometers to our town, received a barbae pseudofolliculitis with keloid infected, festering responsible for the marginalization of the patient, evolving from more than 10 years. The size of the keloid tumor was 12 centimeters broad, covering the entire chin and extended to the cheeks (Figure 2a), obstructing the movements of the neck.

The treatment consisted first of local care during seven days, oral antibiotherapy, followed secondly by surgical removal under general anesthesia. We used cold steel scalpel and the dissection was deeper than the hair follicles. We noted an important bleeding obstructing the movements of the neck.

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Figure 2: Keloid of the chin extended to the cheeks patient 2 (a), the same patient with hypertrophics scars fifteen weeks after surgery (b).
dressing was planned and was marked by diffuse hemorrhage. Finally 10 days later, a skin graft taken on the thighs and performed with 6/0 interrupted monofilament sutures. Continuous monitoring was done by dressing the wound. The suutures were removed after 14 days. Intralesional corticosteroid (triamcinolone) was injected every three weeks. On the re-checkup after 15 weeks, there was a hypertrophic scars of the boundaries (Figure 2b) which remained even after 5 months.

Discussion

Keloids are benign tumors of the dermis typically arising after insult to the skin [1]. The name Keloid was given in 1806 by Baron Jean-Louis Alibert. The word is derived from the Greek chele, meaning crab crinins, and the suffix oid, meaning like.

They usually occur at the site of injury, or may also arise spontaneously. Most skin injury types can contribute to scarring. This includes burns, acne scars, chickenpox scars [2], ear piercing scratches, surgical cuts, and vaccination sites. They tend to overgrow in the area of injury, producing a lump larger than the original scar. They should not be confused with hypertrophic scars that do not grow beyond the boundaries of the original wound.

Keloids are results of an overgrowth of granulation tissue (collagen) at the site of a healed skin injury but the cause of the proliferation of collagen still remains unknown. Keloids tend to have a genetic component however; no single gene has yet been identified. Indeed, studies have shown that people with darker skin have a higher risk of keloid. They occur in individuals with African, Asian or Latino ancestry significantly less than those of Caucasian background. Giants keloids are uncommon. According to our pubmed research, giant corneal [3], buttock [4], perineal [1], plantar [5], and post chickenpox [2] cases were described.

For all these cases cited above and in present study, repeated traumatisms and permanent infection could be at the origin of repeated healing processes which could support occurrence of giants’ keloids. Indeed, we noted that our patient was traditionally scarified (Figure 2b) on the cheeks and did not develop keloid. It is a practice more and more abandoned in our country, carried out on young children to recognize members of the same ethnic group. Finally, these giants keloids could also be explained in our context by the long time of consultation, five years for the first patient and more than 10 years for the second.

This highlights the recurrent problem of accessibility of our hospitals due to the poverty of the populations and the lack of health insurance system. Our first patient did not come for follow up because she was unable to pay the cost of the trip.

There is not universally accepted treatment protocol of keloid. There are broad ranges of therapeutic strategies including pressure therapy, silicone gel sheeting, intra-lesional corticosteroid injection, cryosurgery, radiation, laser therapy, 5-FU, interferon and surgical excision as well as a multitude of extracts and topical agents. Surgical excision is currently still the most common treatment for a significant amount of keloid lesions and is for us mandatory for giants keloids.

However, when surgery is used alone, there is a large recurrence rate. So the others therapies can be used as an adjuvant to surgical excision. Various types of keloid removal are described. In our context, because of the poverty of the patients, primary closure of the defect as our first case constitutes the method of choice. However when the defect is wide, excessive skin tensions support occurrence of keloid.

When primary closure is not possible, skin grafting can be used like our second case with the disadvantage to have a new site of keloid. Some authors use after excision secondary intention healing [6] and obtained wound closure in 6 to 10 weeks. This method which use after surgery only repeated dressing of the wound by the patient or a family member required a long period of care and would be difficult to apply in our context. Indeed, very few persons are able to manage adequate dressing and the risk of infection is very high.

Others [7] use keloid core excision without any adjuvant therapy. We are not accustomed to this interesting method which excise the inner fibrous core from the keloid and cover the defect with a keloid rind flap. Elsewhere such excision would let in our second case barbae follicles and could be not effective. According to the authors of this method, the keloid core extirpation was use to treat keloids of the ear, the trunk, the face and the genital area and prevent recurrence with good results.

We used after excision the only adjuvant treatment available in our hospital to prevent recurrence, the intraleisional injection of triamcino.

According to some authors [1,8] radiation therapy after surgery has better results than corticosteroid injection. Sclafani and et al [8] obtained only 12.5% of recurrence with radiotherapy versus 33% of recurrence with corticosteroid intralesional injection after removal, but the difference was not statistically significant; however rare secondary malignancies (6.7% of cases) [1] were observed with radiotherapy.

Conclusion

In our opinion surgical removal is the best treatment for giant keloid. The intralesional injection of corticosteroid after excision seems to move back the time of recurrence; however the prevention of keloid tumor after surgery still remains in our context a great challenge. We hope that the project, in our country, of universal healthcare insurance and radiotherapy unit will bring us in the future better solutions for keloid prevention and treatment.

Conflict of Interest

Authors declared that they have no conflict of interest to disclose.

References


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