Bowen's Disease:*
A Case Report

MONTE EDWARDS, M.R.C.S. (Eng.)
Baltimore, Maryland

This case of Bowen's disease will add one to about 70 reported in medical literature. My excuse for publishing it is that it presents some atypical features and that its cure required extensive surgical procedures.

Report of a Case

A white man, aged 49 years when first seen by a colleague in September 1951, complained of "rectal irritation" of several years' duration. Rectal examination revealed a flat lesion in the perianal region, with well-defined margins more pronounced on the right. It was of bluish cast, friable, and of leathery consistency. The surgeon warned the pathologist of the possibility of malignancy, but the lesion was reported "anal polyp." Seen again in May 1953, the patient showed no apparent improvement and he was re-admitted to the hospital and the lesion was removed totally. The wound was covered by a skin graft of which there was a 65 per cent take. Again the true nature of the lesion was not recognized, the tissue diagnosis being "multiple sebaceous cysts of the perianal skin." Healing was complete within a few weeks and the patient was asymptomatic until 1955, when a recurrence appeared in the grafted area, and proliferation made its appearance, for which x-ray therapy was administered. His subsequent visits to his medical advisers were very erratic, and he was not seen again until October 1962.

I examined him on October 12, 1962, when the lesion had extended 6 to 8 cm. from the anus, was somewhat flattened in its posterior aspect, was quite vegetative anteriorly, almost flesh colored, but with a purplish cast, and of fairly firm consistency. The margins were quite well defined, and medially the lesion replaced the entire squamous lining of the anal canal. The surface was generally smooth, but was partly covered by scales (Fig. 1).

The patient was barrel-chested, markedly obese, weighing 220 pounds, and his height was 67 inches. He was a heavy smoker, consuming 80 cigarettes a day. He suffered from a chronic cigarette cough and was dyspneic, all of which contributed in some measure to his unsatisfactory postoperative course.

Subsequent treatment was predicated on the failure of all previous forms of therapy, on the malignant potentiality of the disease, and the danger of metastatic involvement of regional lymph nodes. Other forms of therapy were considered, but were rejected. A Miles abdominoperineal excision was performed on November 21, 1962, and terminal colostomy was performed. The lesion, with a margin of about 1 cm. of normal skin, was removed by cutting current (Fig. 2).

The pathologist's report was as follows: "This specimen consists of skin showing an ulcerated dyskeratotic lesion which is surrounded by a distinct zone of normal-appearing stratified squamous epithelium."

The biopsy of the anal lesion revealed a picture pathognomonic of Bowen's disease.

* Received for publication January 6, 1965.
Fig. 2. Operative specimen, including that portion of bowel removed by abdominoperineal resection. Note extension of lesion well into anal canal with rectal mucosa directly above upward spreading margin, precluding possibility of doing any anus-saving procedure.

Fig. 3. Low-power photomicrograph. Dyskeratosis and usual changes of malignancy.

Fig. 4. High-power photomicrograph. Note cells which look almost like Paget cells, with pyknotic nucleus surrounded by clear cytoplasm. There are many mitotic figures.

Fig. 5. End result; healing without skin graft.

epithelium. The lesion is characterized by parakeratotic epithelium showing hyperplastic pegs. The epithelial cells vary in size, shape and chromaticity. This abnormal epithelium is indistinctly stratified. Scattered corps ronds are identified.

The subepithelial connective tissue is infiltrated by lymphocytes and plasma cells. Rare polymorphonuclear leukocytes are seen in the region of the ulceration. A margin of normal tissue is seen on the deep aspect of this section. Pathological Diagnosis: Bowen's disease. One reactive lymph node (Fig. 3, 4).

Some minor surgical problems incidental to the patient's corpulence were encountered, but the postoperative course was uneventful until the sixth day when, due to dyspnea and persistent coughing, the abdominal wound disrupted above the level of the colostomy, requiring secondary closure with silver wire and Davy buttons. The subsequent course in the hospital was not entirely uneventful, but with steady improvement, the patient was discharged on December 16, 1962.

Subsequently it was found that the right inguinal swelling had persisted, and another operation was