

Periungual acquired digital fibrokeratoma

A 35-year-old female presented with an asymptomatic, slow growing, pedunculated growth on the first toe of her right foot for the past six years. On examination, there was a 2-cm-pedunculated, flesh colored growth arising beneath the proximal nail fold with multiple digitations on the surface [Figure 1] and surrounding collarette. Also, seen under the proximal nailfold was a small nodule which continued as a linear depressed groove seen on the lateral margin of the thickened and yellowish nail plate. There was no history of epilepsy or any lesions of tuberous sclerosis on examination.

The lesion was completely excised along with the proximal nodule with a wedge-shaped incision over the proximal nail fold. The histopathological section showed hyperkeratosis, acanthosis, and branching rete ridges in the epidermis. The dermis (core of the lesion) showed thick collagen fibers and blood vessels arranged along the long axis of the lesion. On the basis of histopathological findings, a diagnosis of acquired digital fibrokeratoma (AFK) was made. There was no recurrence of the lesion on follow-up and the development of new nail plate was normal.

Reed and Elmer' distinguished three histological



Figure 1: Pedunculated, flesh colored growth arising beneath the proximal nail fold with multiple fine digitations on the surface mimicking garlic clove fibroma

variants: AFK, irritation fibroma, and fibroma molle. AFK presents as a solitary, elongated or dome-shaped lesion with a characteristic collarette of raised skin at the base. Most common sites of occurrence are fingers and toes but lesions on palms and soles can also occur. Often, the lesion emerges from beneath the proximal nail fold with a narrow base and hyperkeratotic tip (acquired periungual fibrokeratoma). In the latter case, the lesions may be multiple and grow on the nail plate causing longitudinal grooves. Occasionally, AFK may be pedunculated and the surface may appear warty. The condition occurs solely in adults and is believed to result from trauma.

Clinically, the condition may be mistaken as a rudimentary, supernumerary digit, which occurs at the base of the fifth finger, but is present since birth and usually bilateral. Histologically, presence of numerous nerve bundles at the base distinguishes the latter from AFK. Other conditions to be differentiated are cutaneous horn, viral wart, onychomatricoma, dermatofibroma, and Koenen tumor of tuberous sclerosis. The hyperkeratotic tip of the periungual lesion differentiates it from garlic clove fibroma. The condition is benign and surgical excision is curative. Periungual lesions arising below proximal nail folds are to be excised with due care, not to damage the matrix, which may result in permanent nail dystrophy.

Our case is unusual because of the large size of this AFK in periungual region and presence of garlic-clove-like minute projections from its surface and the size of this fibroma causing a longitudinal groove in the nail plate owing to pressure effect over the nail matrix.

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