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Case report

Temporoparietal scalp keloid: an unusual occurrence

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Case report

A 45-year-old man presented to our division with a left temporoparietal scalp keloid. He reported that three years before presentation he had accidentally hit the left parietal region of his head on the sharp end of his bedpost. A resultant laceration was left to heal by secondary intention. The wound healed within 10 days. He observed that the scar, though painless, progressively increased in size for three years and extended beyond the margins of the original injury, thereby resulting in a keloid scar. Unorthodox treatment led to hypopigmentation of the scar without any reduction in size. He has no family history of keloids.

Examination revealed a firm, multilobulated, hypopigmented keloid scar on the left temporoparietal scalp measuring 11 × 11 cm (Fig. 1).

He had a triple therapy comprised of intralesional excision and split thickness skin graft, postoperative low-dose radiotherapy (three fractions of 6 Gy started on the second day postsurgery and completed within five days), and systemic triamcinolone acetate (40 mg intramuscularly weekly for six weeks). The features of the histology report were in keeping with a keloid scar.

The postoperative result at six months is satisfactory, and there are no features to suggest a tendency towards recurrence. The resulting alopecia was acceptable to him (Fig. 2).

Discussion

Scalp keloids are characteristically located on the lower occipital and nuchal areas.[1] Here, they occur as a complication of acne keloidalis nuchae and other inflammatory conditions. There has been no report to our knowledge of post-traumatic scalp keloids occurring on other areas of the scalp. In a review of 295 patients who had skin graft

Figure 1 Left temporoparietal scalp keloid

Figure 2 Area of alopecia 6 months after skin graft

harvested from the scalp, none of them developed keloid as a complication.[2] Keloids are described clinically as raised scars that extend beyond the boundaries of the original wound. They do not regress spontaneously in contrast to hypertrophic scars and occur in genetically predisposed individuals.[3,4] They are found commonly in the African, Afro-Caribbean, Hispanic, and Asian populations.[5] Pathologically, they are formed as a result of an abnormal wound healing process whose prolonged proliferative phase allows a state of continued production of excess collagen developing over a period of months to years at sites of trauma or surgery.[6] Keloids have a predilection for sites, namely the anterior chest, shoulder, ear lobe, bearded area, and lower abdomen.[7] The occurrence of keloids on other anatomical locations such as the genitalia and palmar and plantar surfaces has been rarely reported.[8] The major concerns in this patient are that of recurrence of the scalp lesion, and occurrence of keloid scars at the skin graft donor site. Multimodal therapy reduces the risk of recurrence of keloids.[9] Other modalities in the management of keloids include intralesional or systemic corticosteroids, pressure therapy, silicone gel, immunotherapy, chemotherapy, cryotherapy, and lasers. A useful rule in the treatment of keloids that require surgical excision and split thickness skin graft is that the skin graft donor site should be from sites where a pressure garment is easily applicable. Caution should be exercised when harvesting skin from the scalp of genetically or racial predisposed individuals.

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