Giant relapsing earlobe keloid – Successful combined treatment by surgery and pressure earring

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Abstract
Keloids of the earlobe are frequent. The effective treatment remains a challenge. Intralesional injections, topical corticosteroids, cryotherapy, radiotherapy, laser therapy, and pressure dressings represent some treatment options. To demonstrate the effectiveness of positive pressure dressings after surgical excision to prevent recurrence of earlobe keloid. 2 weeks after surgical excision, the patient was instructed to wear pressure earrings. The dressing was worn for at least 12 h a day during 6 months. The patient was followed 3 years after the surgery. There was no recurrence of the earlobe keloid. Pressure earring was effective for prevention of relapsing keloid scar after surgical removal.

Keywords: Earlobe keloid, prevention, piercings, treatment

Introduction
Keloids are defined as hyperplastic scars that exceed the boundary of the original trauma or as benign dermal tumors. Keloids may develop even after minor skin injuries, such as body piercing. The incidence of keloids has also a genetic background illustrated by the higher risk of keloids in populations of darker skin, such as Africans and Asians. Earlobes are one of the most common anatomical sites for acquired keloids.1

Pathologically, fibroblasts from keloids show peculiarities. They are metabolically hyperactive and show an increased migratory activity in cell culture. As a result, collagen 1 and collagen 3 expressions is higher than in normal skin. Insulin-like growth factor-1-inhibition results in decreased and normalized keloid-fibroblast activity in vitro.1 In a recent microarray study on long non-coding RNAs, an increased expression of the following genes was found in keloid-fibroblasts: FNDC1, CILP2, THBS4, NPTX2, COL5A1, GRIN2D, and CTHRC1. Other genes were downregulated.2 Further studies are needed to fully understand keloid etiopathogenesis.

Earlobe keloids have been classified five different subtypes according to their macromorphology: Single nodular sessile, pedunculated, multinodular sessile, buried, and mixed type.3

Case Report
A 25-year-old male patient presented with a relapsing earlobe keloid. The primary injury was earlobe piercing. He already underwent several treatments such as intralesional injections of corticosteroids, and surgery 5 years ago but experienced a major relapse. He suffered from pain, discomfort, and itching.

On examination, we observed a giant pedunculated earlobe keloid on the left ear with a maximum diameter of about 5.5 cm [Figure 1].

Treatment
We performed complete surgical excision under local anesthesia. 1 week after the surgery the stitches were removed. A pressure earring made by the patient himself using some old earring of his mother was used thereafter. We reevaluated the patient 6 months later without a recurrence [Figure 2].

10 months later, he returned with some itching sensations which were treated successfully by topical corticosteroid ointment. The follow-up was 3 years without any relapse of
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Discussion

Body piercing has become a popular method of body modification. Earlobe piercing is the most common and widely accepted type of body piercing. Complications in earlobes are significantly more common than in the helix and consist mainly of keloid formation and post-traumatic tearing. In a study from Georgia/US, it was observed that keloids are more likely to develop when ears are pierced after age 11 than before age 11.

The best way to deal with earlobe keloids is primary prevention. When a keloid had been developed surgical treatment alone has a high rate of relapse. Therefore, a complex treatment approach is preferred. Jung et al. combined surgery with repeated postsurgical triamcinolone injections and recorded a relapse rate of 16.6%. Al Aradi et al. treated earlobe keloids by keloidectomy with core fillet flap and adjuvant intralesional steroid injection. They achieved an immediate relapse rate of 9.5%. However, anaphylactic reactions have been observed due to triamcinolone injections.

Adjuvant radiotherapy resulted in one study to a reduced recurrence rate of 4%. Short-term adverse effects were not observed. However, since radiotherapy causes stochastic effects, there is no completely safe treatment in the long-term perspective, and the indication has to be considered critically.

Adjuvant pressure after surgical excision reduces the rate of relapses. In a study of Park and Chang, the recurrence rate dropped down from 17.5% to 5%.

The treatment of relapsing or treatment-recalcitrant earlobe keloids is an even greater challenge. In the present case, a large pedunculated earlobe keloid was treated successfully by surgery followed by pressure earrings. There was no relapse of the keloid during follow-up of 3 years.

References

7. Al Aradi IK, Alawadhi SA, Alkhawaja FA, Alaradi I. Earlobe keloid (relapse) on the left ear. (a) Lateral view, (b) posterior-anterior view
8. Figure 1: Clinical presentation of a giant pedunculated earlobe keloid (relapse) on the left ear. (a) Lateral view, (b) posterior-anterior view
9. Figure 2: Clinical result 6 months after surgery and pressure earrings without any relapse. (a) Lateral view, (b) posterior-anterior view
10. Figure 3: Outcome 2 years after surgery with esthetic result and no relapse