We report on a 63-year-old male who was found to have an acrochordon on his plantar foot. Although acrochordons constitute a common benign clinical finding, this observation represents, to our knowledge, only the second case reported on the foot and the first occurring on the plantar surface. (J Am Podiatr Med Assoc 105(5): 440-442, 2015)

Acrochordons, also known as fibroepithelial polyps and colloquially as skin tags, are benign lesions that commonly occur in the axilla, neck, inframammary, and inguinal regions. Although skin tags are believed to arise in part from increased friction, only one published case report has observed a single acrochordon on the dorsum of the foot, and, to our knowledge, an acrochordon on the plantar foot has never been reported. Herein, we describe an acrochordon on the plantar foot of a nondiabetic man.

**Case Report**

A black man in his 60s presented with a lesion on the bottom of his right foot. He reported that it had been present for approximately 15 years and was painful only on stimulation. Clinical examination revealed a 0.7 × 0.7 × 1.5-cm pedunculated, skin-colored papule on the plantar surface of his right foot (Fig. 1).

The patient's medical history included hypertension, peripheral nerve disease, gastroesophageal reflux disease, obesity, benign prostate hypertrophy, seizure disorder, and paranoid schizophrenia. He had no history of diabetes mellitus. His medications included aspirin, finasteride, hydrochlorothiazide, olanzapine, omeprazole, and tamsulosin.

The clinical differential diagnosis included eccrine poroma, verruca, pedunculated seborrheic keratoses, cutaneous horn, neurofibroma, nevus, hamartoma, and fibroepithelioma. A shave biopsy sample was sent for histopathologic analysis, and hematoxylin and eosin staining revealed an acanthotic epidermis with acral-type hyperkeratosis. The stroma was composed of dense collagen and thickened ectatic blood vessels, pathologic findings characteristic of an acrochordon (Fig. 2).

**Discussion**

Acrochordons are found in approximately 25% of adults, and although their pathogenesis is unknown, skin tags have been associated with increasing age, female sex, human papillomavirus types 6 and 11, pregnancy, non–insulin-dependent diabetes mellitus, obesity, pseudo-acanthosis nigricans, seborrheic keratoses, and increased friction. The latter factor is thought to be responsible for its anatomical predilection for the neck and axilla, but acrochordons are also commonly observed on the face, chest, groin, and, less frequently, other areas of the body. A review of the literature yielded only one report describing an acrochordon occurring on the foot, specifically overlying the dorsal first and second metatarsals in a healthy, athletically active 18-year-old man.

Acrochordons can typically be diagnosed clinically and must be differentiated from pedunculated dermal nevi and neurofibromas, which may have more prominent implications for management. Skin tags can also appear grossly similar to eccrine poromas, but the latter’s histologic findings of densely packed cuboidal basaloid cells with con-
Pedunculated seborrheic keratosis can have histologic features similar to acrochordons, as horned pseudocysts may be present in both of these lesions; however, basaloid cell proliferation is considered to be a sensitive diagnostic criterion for pedunculated seborrheic keratosis. In this case, the lesion lacked horn pseudocysts and basaloid cell proliferation. It demonstrated acanthotic epidermis with acral-type hyperkeratosis and dense stromal collagen with ectatic blood vessels, which confirmed the diagnosis of acrochordon (Fig. 2).

Harmless in nature, acrochordons are generally treated only for frequent irritation or cosmetic reasons. Therapeutic options include snip excision, cryosurgery with liquid nitrogen, and electrodessication. This patient’s lesion was removed by shave biopsy under local anesthesia. Healing was unevent-

**Figure 1.** Clinical images. A, A caudal-cranial view of the patient’s plantar right foot with a 0.7 × 0.7 × 1.5-cm acrochordon. B, Higher magnification of the lesion on the patient’s right plantar foot.

**Figure 2.** Histopathologic findings. A, The section of the polypoid mass showing a fibroepithelial polyp. Acanthotic epidermis with acral-type hyperkeratosis and stoma composed of dense collagen and ectatic blood vessels (H&E, x10). B, Higher magnification showing the dense stromal collagen with ectatic blood vessels. The acanthotic epidermis shows hypergranulosis and acral-type hyperkeratosis (H&E, x20).
ful, and follow-up at 3 months demonstrated no recurrences.

To our knowledge, this report is the first to describe an acrochordon on the plantar surface of the foot. It is not known whether this is due to rarity, underdiagnosis, or underreporting. Overall, the pathogenesis of acrochordons is sparsely studied, likely due to their benign nature. Unusual cases such as this may help in the future elucidation of the pathogenesis of these common lesions.

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References