

Chapter 16

A 49-Year-Old Woman with a Temporary Bleeding, Solitary Lesion on the Left Temporal Area



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A 49-year-old woman presented with a one-year history of a solitary, brown lesion on the left temporal area. The patient complained of sporadic bleeding from the lesion after hair brushing.

On physical examination, a sharply demarcated, verrucous, brown-pinkish lesion on the left temporal area was presented (Fig. 16.1). Dermoscopy showed a lesion with a sharply demarked border with brown and black hyperkeratotic areas on the left side and pink hyperkeratotic areas with harpin vessels on the right side (Fig. 16.2). On dermoscopy with immersion fluid, comedo-like openings were detected.

Based on the case description and the photographs, what is your diagnosis?

Differential Diagnoses

1. Seborrheic keratosis.
2. Melanoma.
3. Pigmented basal cell carcinoma.
4. Melanotic nevus.

Diagnosis

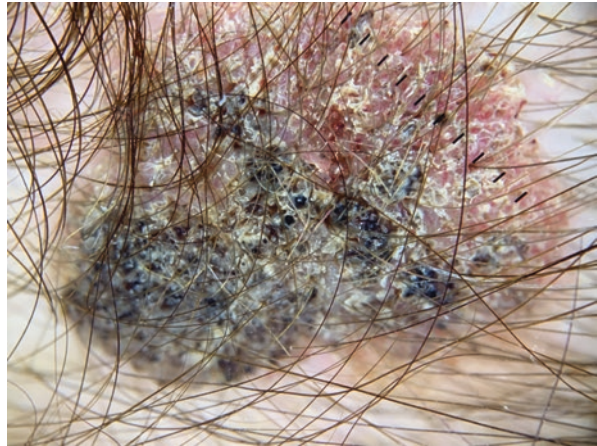
Serborrheic keratosis.

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Fig. 16.1 A 49-year-old woman with a sharply demarcated, verrucous, brown-pinkish lesion on the left temporal area



Fig. 16.2 Dermoscopy shows a lesion with a sharply demarcated border with brown and black hyperkeratotic areas on the left side and pink hyperkeratotic areas with harpin vessels on the right side (×10)



Discussion

Seborrheic keratosis, also known as verruca seborrhoica and seborrheic wart, is one of the most common benign skin tumor that results from benign clonal expansion of epidermal keratinocytes [1]. The etiology and pathogenesis of seborrheic keratosis are still not well understood. However the role of genetic predisposition, older age and ultraviolet light has been suggested [1]. Seborrheic keratosis is most commonly observed in the middle-aged and elderly, however it may also present in young adults. No gender predisposition is observed. Seborrheic keratosis is mostly presented in individuals with low Fitzgerald's skin phototypes [2]. Typical lesion is sharply demarcated, round or oval-shaped, elevated and stuck on the skin with a verrucous, dull, uneven, or punched-out surface. Flat seborrheic keratosis often has

a smooth, velvety surface and is barely elevated above the surface of the skin [1]. The color of the lesions varies from skin color, yellowish, light to dark brown, grey, and black. Seborrheic keratosis may present as an isolated or multiple lesions. The lesions appear anywhere on the body with the exception of the palms, soles and mucous membranes. The chest, back, scalp (mainly the temporal areas) and neck are most commonly affected. Seborrheic keratosis is generally slow-growing and asymptomatic condition. Irritation or trauma may cause itching, pain and bleeding with erythema or crusting [1]. Rarely spontaneous resolution may occur [1, 2]. The diagnosis of seborrheic keratosis is mainly established based on clinical manifestation. Dermoscopy may be helpful to differentiate benign features from dysplastic or malignant tumors. Dermoscopic findings of seborrheic keratosis are milia cysts, comedo-like openings, fissures and ridges, hairpin blood vessels, sharp demarcation, and moth-eaten borders [3]. In case of ambiguity or features of malignancy such as ulcerated or large lesion and rapid change in size, a skin biopsy with histopathological examination may be recommended [2]. In histopathological examination, a proliferation of keratinocytes with keratin-filled cysts are typically observed [2]. In inflamed or irritated lesions lymphocytic infiltration may be present. There are numerous histopathological subtypes of seborrheic keratosis that vary in degrees of hyperkeratosis, acanthosis, pseudocysts, hyperpigmentation, inflammation, and dyskeratosis [1, 2]. Seborrheic keratosis is benign and typically does not require any treatment. However, lesions are frequently removed because of esthetic reason. The therapeutic options include cryotherapy (liquid nitrogen or CO₂), shave excision or topical agents (tazarotene, imiquimod cream, alpha-hydroxy acids, and urea ointment) [2].

Differential diagnoses for the presented patient were melanoma, pigmented basal carcinoma and melanotic nevus.

Melanoma is the most fatal form of skin cancer which most commonly affects the adult population. The typical cutaneous melanoma occurs as an asymmetric macule or nodule with irregular borders, frequently with variations in color within the lesion. Pink or red lesion may be also presented [4].

Basal cell carcinoma is the most common type of skin malignancy. The incidence rate of the disease increases with age. Basal cell carcinoma presents as a tiny, hardly visible papule, growing into a nodule or a plaque that is sometimes ulcerated [5]. The face, scalp or neck are most commonly affected.

The scalp is an anatomical location for nevi with site-related atypia, a subset of melanocytic nevi that share histologic features with melanoma but that are benign. The clinical patterns of the scalp melanotic nevi are solid brown, solid pink, eclipse and cockade. The lesions are mostly presented on the vertex and the parietal area [6].

Based on the clinical presentation and dermoscopic features, the diagnosis of seborrheic keratosis was established. Cryotherapy with liquid nitrogen was performed with resolution of the skin lesion.

Key Points

- Seborrheic keratosis is a benign skin tumor which may affect the scalp area.
- It presents as a sharply demarcated, round or oval-shaped, elevated and stuck on the skin lesion with a verrucous, dull, uneven, or punched-out surface.
- The color of the seborrheic keratosis varies from skin color, yellowish, light to dark brown, grey, and black.

References

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