



Seborrheic keratosis of the breast mimicking melanoma

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Abstract

Seborrheic keratosis is a common skin lesion that can usually be recognized either clinically or dermoscopically. However, seborrheic keratosis with atypical clinical and dermoscopy presentation are increasingly reported. The main objective in differential diagnosis is to discriminate seborrheic keratosis from malignant conditions, and especially melanoma, in order to determine correct treatment pathways as early as possible. We report a case of a 66-year-old woman with an atypical clinically and dermoscopy pigmented lesion of the breast, mimicking melanoma.

Received: Dec 03, 2018

Accepted: Jan 03, 2019

Published Online: Jan 04, 2019

Journal: Annals of Obstetrics and Gynecology

Publisher: MedDocs Publishers LLC

Online edition: <http://meddocsonline.org/>

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Keywords: Seborrheic keratosis; Melanoma

Introduction

Seborrheic Keratosis is one of the most commonly observed benign skin tumours in everyday clinical practice. In their typical form, it appears as variably pigmented patches and nodules, often affecting elderly people [1]. Despite an often unsightly appearance which can be frightening for the patient, a dermoscopic examination usually enables a clear-cut diagnosis of the disease with typical features [2]. However, Seborrheic keratosis with atypical dermoscopy presentation are increasingly reported. These lesions sometimes mimic melanoma, thus complicating the differential diagnosis [3]. We aim to present a non-typical case of seborrheic keratosis with atypical dermoscopy presentation, observed as a pigmented lesion of the breast mimicking melanoma.

Case presentation

A 66-year-old woman, with 6-year history of an ischemic cerebral stroke complicated by left hemiplegia. The patient's medical and family history of cutaneous diseases was negative.

She presented 8 months' history of an asymptomatic bleeding pigmented lesion of the right breast. Dermatological examination revealed a 3 cm black, multilobed, pedicled tumor, firm in consistency with well-defined borders on erythematous background of the right breast (Figure 1). Dermoscopy showed heterogeneous pigmentation, linear vessels and brown globules (Figure 2) with the absence of comedo-like openings. From the clinical and dermoscopic point of view the lesion appeared suspicious. The diagnosis of melanoma was strongly being made



Cite this article: EL Jouari O, Elloudi S, Senhaji G, Baybay H, Mernissi FZ. Seborrheic keratosis of the breast mimicking melanoma. *Ann Obstet Gynecol.* 2019; 2(1): 1006.

through the history, clinical examination, dermoscopic features and the rapid growth of the tumor. A total excision of the lesion was performed. To our surprise, histopathological examination showed exophytic proliferation of epidermal cells. The lesion exhibited papillomatosis, hyperparakeratinization, acanthosis and deep, keratin-filled invaginations. Keratotic invaginations with intraepithelial keratin cysts were present. Melanin pigmentation was observed in the basal layer. The dermis exhibited collagen fibers, blood vessels and moderate inflammatory infiltrate (Figures 3,4). At 7 months of decline, no recurrence was noted.



Figure 1: A 3 cm black multilobed pedicled tumor of the right breast.

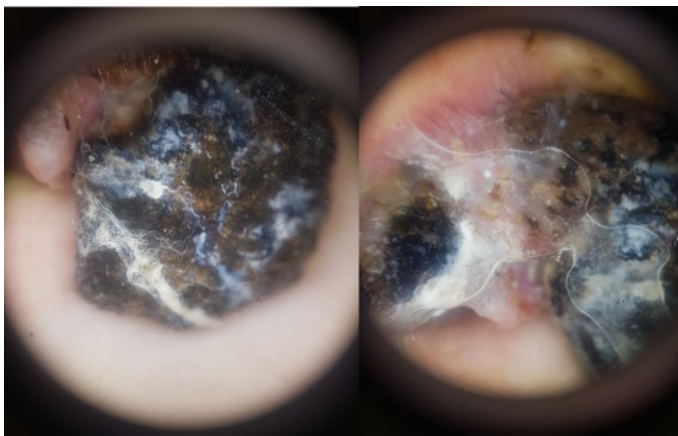


Figure 2: Dermoscopy showing a heterogeneous pigmentation, linear vessels and brown globules.

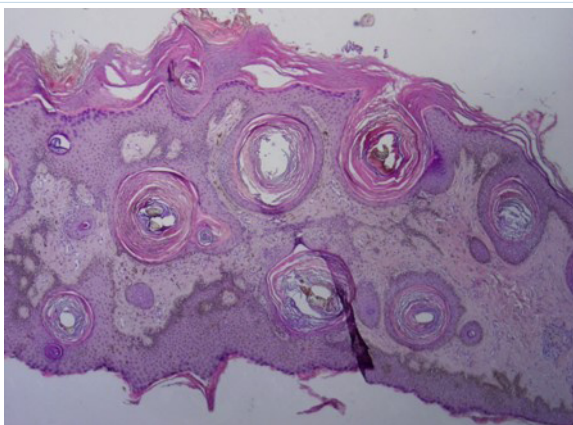


Figure 3: Histologic findings: pseudohorn cysts in the epidermis opened to the surface of the lesion and intraepidermal cysts.

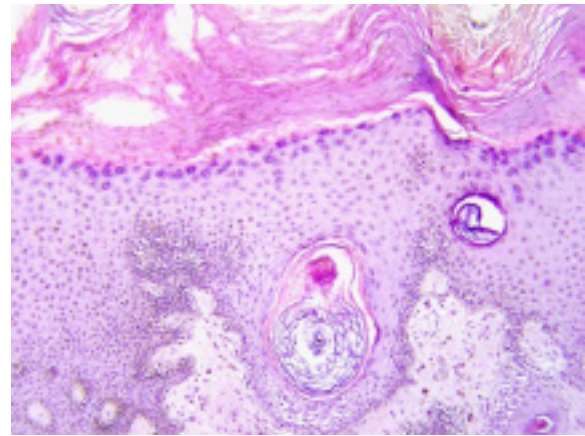


Figure 4: Histologic findings: papillomatous surface of the epidermis with enlarged capillaries of the dermal papillae.

Discussion

Seborrheic keratosis is a common benign tumor, the diagnosis is, in general, a clinical one.

It appears as variably pigmented patches and nodules, often affecting elderly people [1]. But in some cases, the differential diagnosis between pigmented seborrheic keratosis and malignant melanoma is difficult [4]. Although, Dermoscopy is a non-invasive helpful tool in diagnosis of seborrheic keratosis [5]. Typical dermoscopic features that we commonly use to identify seborrheic keratosis, were systematically described and included in a dermoscopic algorithm in 2003 by Argenziano et al, such as multiple milium-like cysts, comedo-like openings, fissures, finger-print structures and sharply demarcated borders [2]. A series of additional dermoscopic criteria to increase diagnostic accuracy, underlining fissures, hairpin vessels, sharp demarcation and moth-eaten borders were proposed. Later, Scope and al observed that some typically melanocytic dermoscopic features, such as pigmented network, aggregated globules, streaks and homogeneous blue colour, were also present in seborrheic keratosis and other non-melanocytic lesions [3]. As a consequence, when characteristic features of seborrheic keratosis are observed at dermoscopy, a differential diagnosis is simplified. In our case, we believe that the original misdiagnosis resulted because of the absence of these findings at dermoscopy. Reflectance confocal microscopy is also an optimal non-invasive examination for early differential diagnosis of seborrheic keratosis with atypical dermoscopy presentations. Therefore, It may be able to assist in differential diagnosis and avoid unnecessary excisions [3]. Histopathology should remain mandatory for seborrheic keratosis with atypical dermoscopy and without a clear differentiation from other malignancies at dermoscopy [6]. The management of these atypical seborrheic keratosis remains undefined, often requiring a final excision of the lesion to reach a correct diagnosis [7]. To complicate the picture, melanomas mimicking seborrheic keratosis have also been reported [8]. Interestingly, the current case shows that seborrheic keratosis can present a challenging clinical appearance, and even expert dermatologists can misdiagnose these difficult cases.

Conclusion

We showed one of the rare clinical and dermoscopic pictures of seborrheic keratosis which suggested melanoma. A histopathological examination is crucial in confirming the diagnosis.

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