

What Can Hide Under Exophytic Verrucous Appearance?

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A 70-year-old Caucasian woman attended our pigmented lesions clinic for routine treatment. On examination, numerous seborrheic keratoses were found on her trunk and limbs. She reported that a lesion in the centre of her abdomen had increased in size over the previous year. Clinical examination revealed a symmetric lesion comprising two well distinct areas of pigmentation, one light brown and the other dark brown, and exhibiting a typical exophytic verrucous appearance (Fig. 1). Dermoscopic evaluation of the whole lesion revealed the presence of pseudo-horn cysts, comedo-like openings and fissures. Moreover, a pigmented network, as well as globules and pseudopods, were found in one part of the lesion (Fig. 2).

A tentative diagnosis of collision tumour involving a seborrheic keratosis and atypical melanocytic lesion was made, and we decided to surgically remove the entire lesion. Histopathological examination of the excised tissue revealed a hyperkeratotic (papillomatous) seborrheic keratosis converging with an exophytic, verrucous lesion (displaying melanocytic activity) at the dermoepidermal junction and superficial dermis. The hyperkeratotic seborrheic keratosis displayed papillomatosis, acanthosis and the proliferation of basaloid cells with a varying admixture of squamoid cells, keratin-filled invaginations and horn cysts. Similar to conventional seborrheic keratosis, there were, at the dermoepidermal junction in the area of skin affected by seborrheic keratosis-like changes, nests of atypical melanocytes, some of which formed pagetoid spread in the epidermal fronds. The dermis, meanwhile, contained

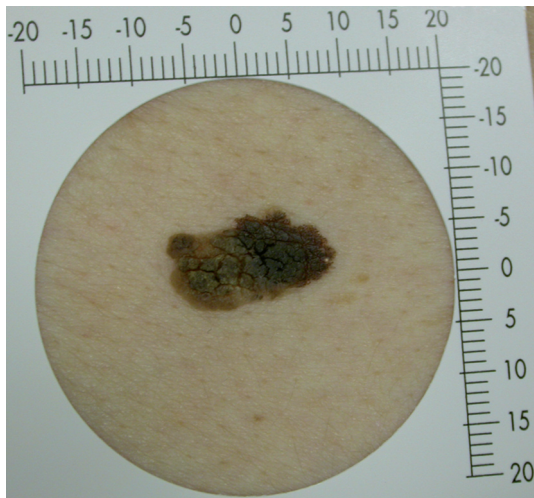


Fig. 1. Macroscopic image of a malignant melanoma arising from a seborrheic keratosis.

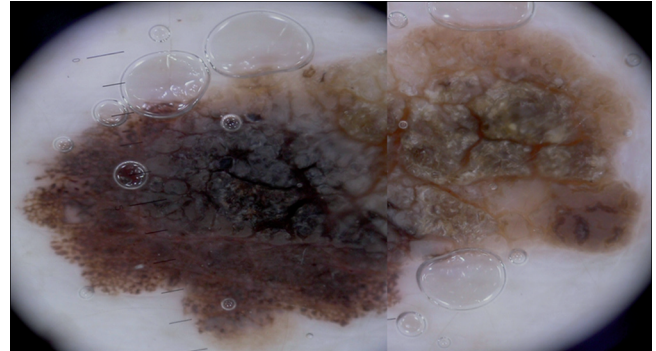


Fig. 2. Dermoscopic image of the same lesion shown in Fig. 1 demonstrating pseudo-horn cysts, comedo-like openings and fissures. One part of the lesion also displayed a pigmented network, globules and pseudopods.

tightly-packed aggregates of small darkly-staining cells resembling naevus cells. These cells displayed hyperchromatic, angulated nuclei, scant cytoplasm and occasionally prominent nucleoli. The final diagnosis was hyperkeratotic seborrheic keratosis in collision with verrucous and keratotic nevoid melanoma (Fig. 3). The melanoma was a Clark level II tumour in the vertical growth phase. It had a Breslow thickness of 0.8 mm.

The development of malignant melanoma contiguous with or adjacent to seborrheic keratoses is uncommon but has been documented previously (1–5).

A retrospective analysis of 618 cases of malignant melanoma (6) identified 10 lesions with marked verrucous and keratotic patterns that were initially clinically diagnosed as benign lesions.

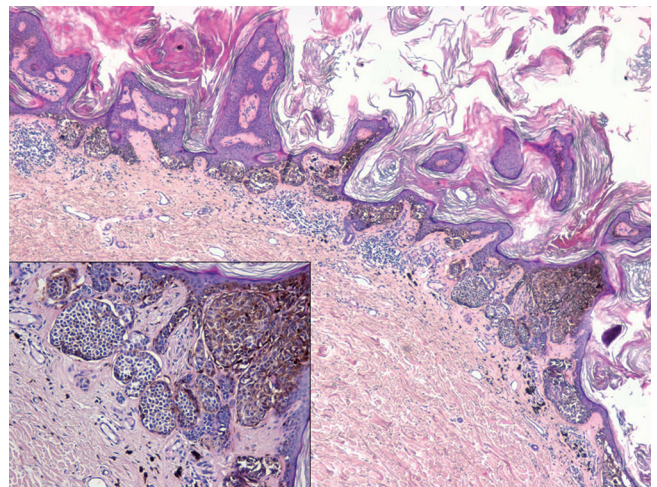


Fig. 3. Hyperkeratotic seborrheic in collision with nevoid melanoma. Melanoma cells are associated with scattered melanophages and signs of fibrosis in the superficial dermis (inset).

In our case, the melanocytic lesion had an architecture characterized by verrucous/exophytic features and the presence of marked hyperkeratosis.

At low magnification, the melanocytic proliferation suggested a naevus, but careful scrutiny revealed impaired maturation, expansile nests and occasional pleomorphic nuclei, more suggestive of verrucous and keratotic nevoid melanoma. We were not able to find any healthy skin between the conventional hyperkeratotic seborrheic keratosis and the verrucous and keratotic nevoid melanoma, although a sampling bias cannot be excluded. The two lesions both displayed prominent hyperkeratosis, papillomatosis and a general exophytic verrucous appearance, and it is thus conceivable that the melanocytic proliferation developed in the context of a pre-existing seborrheic keratosis.

Many physicians remove typical-looking seborrheic keratoses without the use of dermoscopy and without confirming the diagnosis through histopathological analysis. This habit should be abandoned. At the very least, every seborrheic keratosis a doctor intends to excise should be subjected to dermoscopic examination

in order to avoid missing other colocalized malignant lesions, such as melanomas (1–5).

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