

An itchy speckled lesion

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The diagnosis of pigmented lesions is a daily challenge in general practice. Dermatoscopy can provide extra clues, but requires significant expertise. This series will help you hone your skills.

Case presentation

Over a two-month period, a 39-year-old woman noted the development of itching and darkening of an elevated pigmented lesion (Figure 1). The 0.5 cm lesion had appeared on her left arm only in the previous 12 months but had remained stable in size. Dermatoscopy revealed a symmetrical lesion with extensive speckled pigment consisting of blue–black to yellow–white dots and globules. There was no evident pigment network and the central area was pink (Figure 2). The excision specimen showed verrucous epidermal hyperplasia with a prominent loose horny layer. There were several keratin-filled pseudocysts. The junctional zone of the hyperplastic epidermis was obscured by a very marked lymphocytic infiltrate associated with necrotic keratinocytes. Melanin pigment was present in the upper dermis (Figure 3).

Diagnosis

The lesion was diagnosed as a regressing seborrhoeic keratosis.

Discussion

Benign as well as malignant skin tumours may undergo immunological regression. Such pigmented lesions often lose their primary structure and may be difficult to diagnose with dermatoscopy. In this case, the numerous yellow–white pseudocysts, the pale, light brown, waxy appearance of the lesion and the lack of pigment network were points in favour of a seborrhoeic keratosis. The extensive blue–black pigment dots and pink centre were the results of regression. The rapid changes, as well as patient concern, prompted excision biopsy for a definite diagnosis.

Keypoint

Immunological regression alters the primary structure of pigmented lesions and is often associated with the presence of numerous blue–black dots, producing a speckled or reticulate pattern.

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Figure 1. Darkly pigmented papular lesion on the left arm.

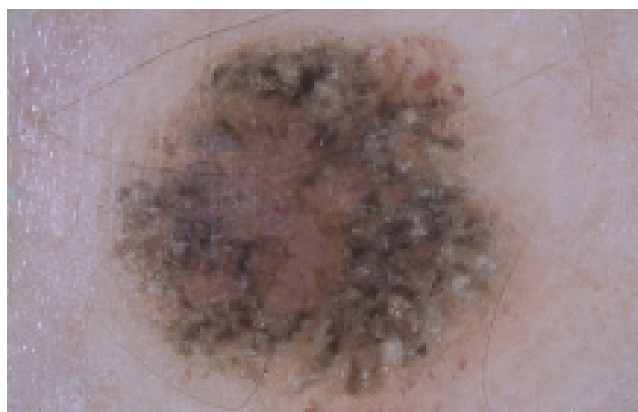


Figure 2. Dermatoscopy revealed numerous blue–black dots in a reticulate pattern, with an admixture of yellow–white microcysts and a pink central zone.

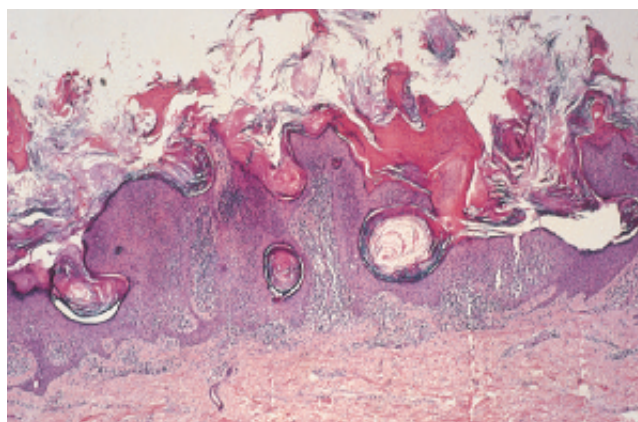


Figure 3. Verrucous epidermal hyperplasia with multiple keratin pseudocysts and prominent lymphocytic inflammation obscuring the junction of the epidermis.

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