

A bleeding lesion with a villous surface

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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 six week period, a 64-year-old man noted an irritated lesion on his anterior chest (Figure 1). The lesion measured 8 mm in diameter and it bled. Dermatoscopy revealed an elevated lesion with multiple pale villous projections that were partially obscured by a black eschar. The surrounding skin had a pink homogeneous hue, but there was no evident pigment network (Figure 2). Excision biopsy showed a markedly papillomatous epidermis covered by a loose stratum corneum containing locules of blood. The epidermis was hyperplastic but lacked evident atypia. There was a prominent lymphocytic infiltrate hugging the epidermal junction at the dermal interface (Figure 3).

Diagnosis

The final diagnosis was an irritated seborrhoeic keratosis undergoing involution.

Discussion

The villous projections seen on dermatoscopy are evident in the skin biopsy as epithelial projections partially covered by blood. Involuting seborrhoeic keratoses are associated with a dense lymphoid infiltrate (which induces necrosis and bleeding), loss of the typical waxy pigment, and pale keratin pseudocysts. An identical clinical pattern can be observed in involuting warts, and skin biopsy is required to detect papillomavirus.

Keypoint

Seborrhoeic keratoses often lose their characteristic dermatoscopic features, and pale villous projections may be the only clue to the correct diagnosis. MT

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Figure 1. Bleeding verrucous lesion on the patient's chest.

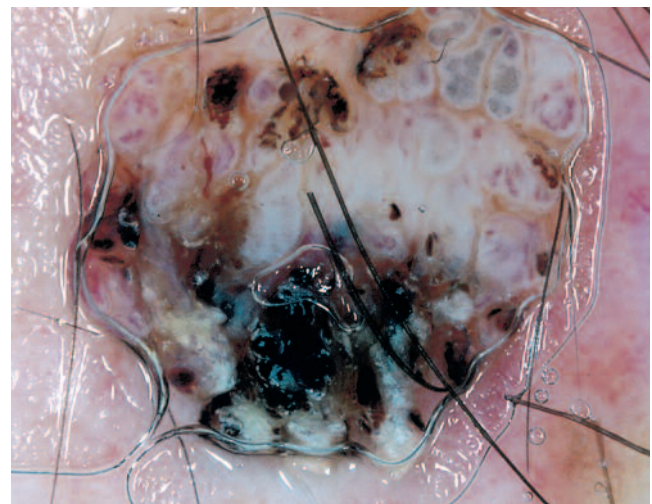


Figure 2. Dermatoscopy demonstrating multiple pale villous projections that are partially obscured by eschar of blood.

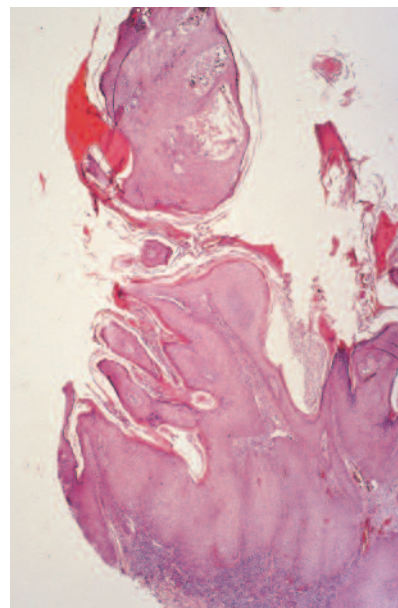


Figure 3. Skin biopsy showing marked epithelial hyperplasia with papillomatosis, adherent blood, and a dense lymphoid infiltrate at the dermal interface.