A friable pigmented lesion

STEVEN KOSSARD FACD

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

An 82-year-old man with multiple seborrhoeic keratoses developed an irritable pigmented lesion (measuring 1.3 cm x 1 cm) on his back (Figure 1). This had bled intermittently over a six-week period and had been itchy. Dermatoscopy revealed an irregular pigmented lesion that had numerous blue–black dots giving a stippled pattern with pale scar-like areas adjacent to a raw bleeding surface (Figure 2). Excision biopsy showed an eroded epidermis with haemorrhage. The upper dermis contained abundant melanin pigment, lymphocytic inflammation and fibrosis. The adjacent epidermis was papillomatous and contained isolated keratin pseudocysts, but there was no melanocytic proliferation or atypia (Figure 3).

Diagnosis

The final diagnosis was an irritated seborrhoeic keratosis undergoing regression.

Discussion

The blue–black dusty pigment dots and pale areas seen on dermatoscopy in this lesion are characteristic of regression. A biopsy is usually required to determine whether a primary lesion can be still recognised. In this case, the adjacent epidermis showed changes of a seborrhoeic keratosis undergoing involution. The possibility of an admixed, fully regressed melanoma could not be entirely excluded, but it appeared less likely.

Keypoint

Dermatoscopy is useful in recognising regression in pigmented lesions, and close study of the clinical features as well as the histopathology may identify the primary lesion. MT

Professor Kossard is Associate Professor, Skin and Cancer Foundation and St Vincent's Hospital, Darlinghurst, NSW.

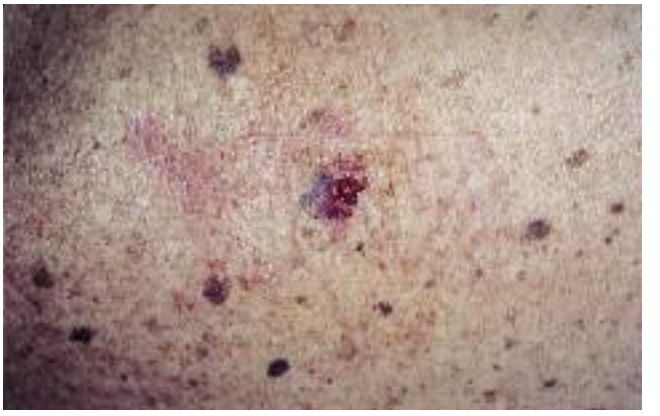

Figure 1. Irritated bleeding pigmented lesion on the patient's back, with multiple surrounding seborrhoeic keratoses.

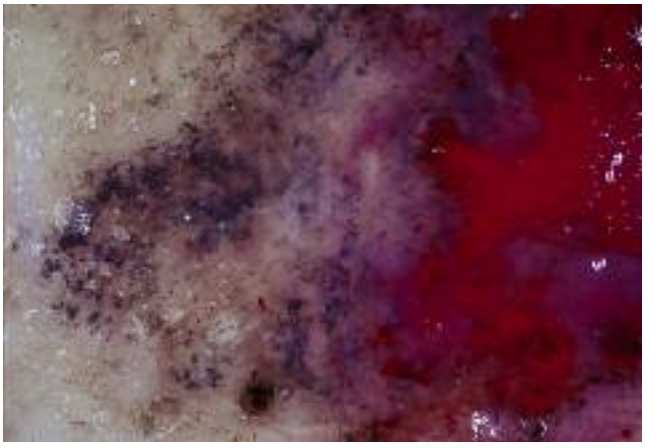

Figure 2. Dermatoscopy demonstrating numerous blue–black pigment dots with pale stippled areas and adjacent bleeding surface.

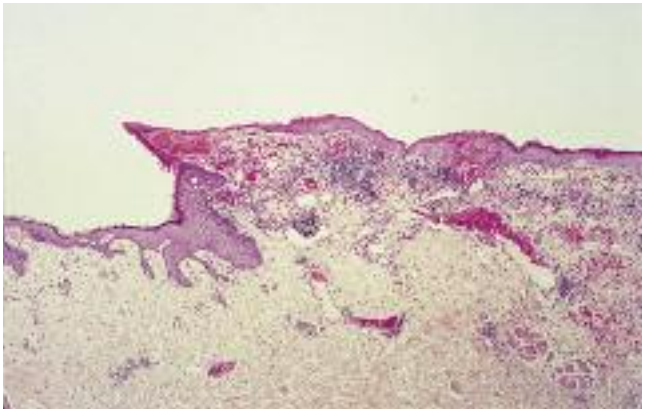

Figure 3. Excision biopsy showing an eroded elevated epidermis with haemorrhage and dusty melanin pigment as well as lymphocytic inflammation in the superficial dermis.