Sessile pigmented lesions

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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 10-year period, a 52-year-old woman developed a series of pigmented papular lesions on her neck and upper trunk (Figure 1). Dermatoscopic examination of the largest lesion showed a well demarcated symmetrical lesion with a smoky tan to light brown colour and numerous yellowish-white globules (Figure 2). The surrounding small papular lesions showed identical findings. A shave biopsy revealed a hypertrophic epidermis associated with small keratinocytes that enclosed multiple large keratin-filled pseudocysts (Figure 3).

Diagnosis

The clinical, dermatoscopic and biopsy findings were those of a seborrhoeic keratosis.

Discussion

Seborrhoeic keratoses are hyperplastic epidermal lesions that produce excess keratin enclosed within pseudocysts, which are seen under dermatoscopy as yellow-white globules. Melanocyte numbers are usually normal in seborrhoeic keratosis, but melanin is retained in the keratinocytes, and the admixture with keratin produces the clinical appearance of a brown waxy lesion.

Keypoint

Dermatoscopy is particularly useful in identifying small dark seborrhoeic keratoses. MT

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Figure 1. Series of sessile pigmented lesions on the patient's neck and shoulder.

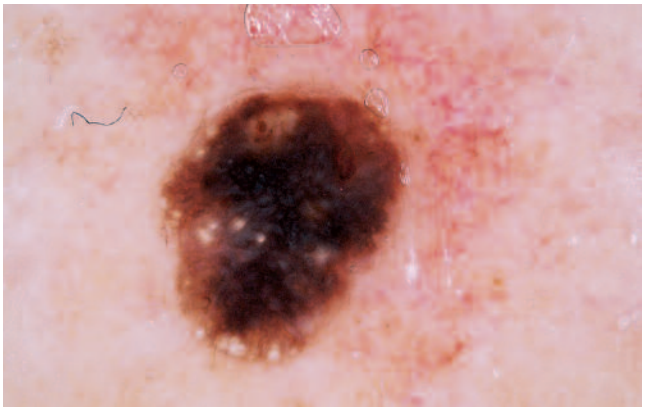

Figure 2. Dermatoscopy showing symmetrical, dark tan lesion with numerous yellow-white globules.

Figure 3. Shave biopsy demonstrating a hyperplastic epidermis enclosing numerous keratin-filled pseudocysts.