

# Paired perioral papules – pick the problem

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With sufficient training and expertise, clinicians can use dermoscopy to improve diagnostic accuracy for melanocytic lesions and other common skin tumours.

## Case presentations

### Case 1

A 58-year-old woman presented for assessment of an enlarging lesion situated on her left chin. She had sought attention for the lesion 12 months previously, but had been reassured that she had a benign facial naevus, which was of no concern (Figure 1). Her husband had noticed that the superior papule had been slowly growing in size. It was otherwise asymptomatic and had never bled or crusted.

On examination there were two flesh coloured papules situated on the left lateral chin with the superior lesion of prime concern to the patient (Figure 2). Each measured approximately 4 mm in maximum diameter and on close inspection both papules had visible surface telangiectasia.

Dermoscopy of the superior dome-shaped papule demonstrated a network of fine arborising vessels (distributed diffusely) on a pale pink background (Figure 3a). Dermoscopy of the inferior papule, which was somewhat elongated, showed few features except for some scattered curvilinear marginal vessels (in poor focus) that did not form an arborising network (Figure 3b). Its colour was that of

surrounding skin and it demonstrated lateral displacement on gentle compression (the so-called 'wobble sign').

### Case 2

A 61-year-old woman, who had a number of facial lesions, presented for a general skin check (Figure 4). She enquired specifically about the removal of some of the

papules, which were bothersome cosmetically for her.

On examination the patient had two prominent papules above and below the left oral commissure (Figure 5). Each measured 5 mm in maximum diameter, and both papules had visible surface telangiectasia. The inferior papule was pale pink and the superior papule was light tan.

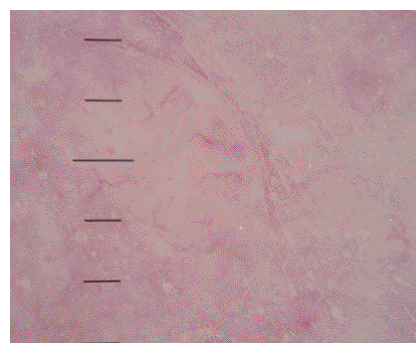
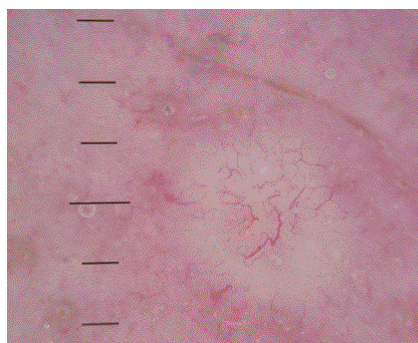
Dermoscopy of the inferior papule showed a broad network of arborising telangiectasia in sharp focus (Figure 6a). Both pigment and ulceration were absent. Accumulated makeup could also be seen within follicular openings. The superior papule, on the other hand, demonstrated a patchy globular pattern with some terminal hairs present peripherally (Figure 6b). A sparse number of curvilinear (comma-shaped) vessels could



Figure 1. Lower face of case 1.



Figure 2. Paired papules on the left lateral chin in case 1.



Figures 3a and b. a (left). Dermoscopy of the superior papule in case 1 demonstrating arborising telangiectasia. b (right). Dermoscopy of the inferior papule in case 1 demonstrating marginal curvilinear (comma-shaped) vessels. The scales shown are marked in millimetres.

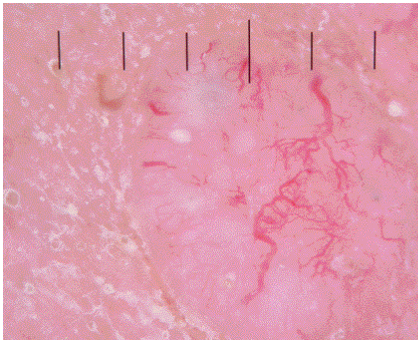
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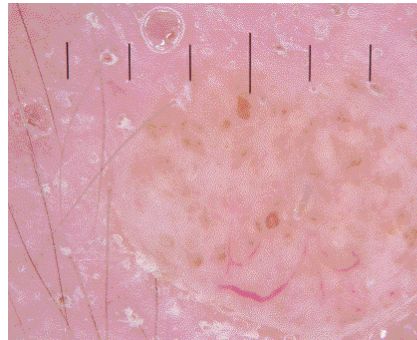
Figure 4. Lower face of case 2.



Figure 5. Paired papules adjacent to the left oral commissure in case 2.



Figures 6a and b. a (left). Dermoscopy of the inferior papule in case 2 demonstrating a broad network of arborising telangiectasia. b (right). Dermoscopy of the superior papule in case 2 demonstrating diffuse tan globules and sparse marginal comma-shaped vessels. The scales shown are marked in millimetres.



also be seen, although they did not form an arborising network. The consistency of the superior lesion was soft and it demonstrated a positive 'wobble sign'.

### Diagnosis

The clinical diagnosis was the same in both cases – a nonpigmented nodular basal cell carcinoma (BCC) adjacent to a benign intradermal naevus. For case 1 the BCC was the superior lesion and for case 2 it was the inferior lesion.

### Discussion

These two cases illustrate the diagnostic value of dermoscopy in differentiating nonpigmented BCCs from facial intradermal naevi. At first glance these lesions can be deceptively similar in appearance, as seen particularly in case 1 (Figure 1).

These cases also highlight that visible macroscopic telangiectasiae are not a reliable distinguishing feature for BCCs.

Nonpigmented BCCs consistently demonstrate a superficial plexus of arborising vessels of varying size and calibre. These vessels are in sharp focus due to their superficial nature and if there is doubt about the diagnosis they are highlighted further by firm rubbing for 10 to 15 seconds with an alcohol wipe, which causes a degree of vasodilatation. They are also uniformly pale pink. Dermoscopy atlases frequently emphasise the features of pigmented BCCs such as leaf-like areas, blue-grey ovoid nests or spoke wheeling. It should be emphasised that pigmented BCCs are less common than nonpigmented BCCs.

Intradermal naevi, on the other hand,

range in colour from tan to pink or flesh coloured and also grow slowly over time until a point of stability. They usually show variable pigment on dermoscopy, which may be homogenous or globular. The vascular pattern usually consists of peripheral curvilinear (comma-shaped) vessels, which are short and in poor focus. These vessels are not highly specific and can be seen in any dome-shaped tumour, whether it is a benign naevus or a cancerous tumour. The 'wobble sign' is a useful sign in distinguishing intradermal or compound naevi. It refers to the displacement or tendency to fold over under gentle lateral pressure by the dermoscope. This is not an absolute sign of benignity (merely a clue) as it may be seen rarely in melanomas. In contrast, sessile seborrhoeic keratoses remain stiff under lateral pressure and are not displaced.

### Keypoint

Most skin coloured facial papules are intradermal naevi. Less common causes include fibrous papules, sebaceous hyperplasia, cysts, mollusca and adnexal tumours. BCCs may mimic intradermal naevi, but dermoscopy helps to reliably identify BCCs because of their consistent vascular morphology. **MT**

### Acknowledgements

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### Further reading

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DECLARATION OF INTEREST: None.