

# Queratose seborreica simuladora de melanoma

## Seborrheic keratosis that resemble melanoma

### ABSTRACT

Seborrheic keratosis are benign epithelial tumors that are usually easily diagnosed through clinical and dermatoscopic examination. They can sometimes resemble malignant lesions, especially melanoma. This article illustrates two such cases, highlighting the detailed dermatoscopic observations that help distinguish these lesions, to help increase the accuracy of diagnoses.

**Keywords:** keratosis, seborrheic; melanoma; dermoscopy.

### RESUMO

*Queratoses seborreicas são tumores epiteliais benignos de diagnóstico usualmente fácil pelo exame clínico e dermatoscópico. Em algumas situações podem simular lesões malignas, em especial o melanoma. O presente artigo tem como objetivo ilustrar dois desses casos e enfatizar a observação dermatoscópica cuidadosa na busca de aspectos menos comuns dessas lesões que podem ser determinantes para o aumento da acurácia diagnóstica.*

**Palavras-chave:** ceratose seborreica; melanoma; dermoscopia

Seborrheic keratosis is a benign epithelial tumor that is formed by epidermal proliferation at the expense of basaloid cells, which can be pigmented. It is more common from the age of 50 and in Caucasians.<sup>1</sup> Its etiology is unknown, but it may run in families and be influenced by growth factors.<sup>1</sup>

Clinically, it manifests as a plaque or papule with a waxy appearance, usually brownish and well delimited, which can manifest in any area of the skin especially in photoexposed areas, excluding the palmoplantar region.

During dermatoscopy, it is mainly characterized by milium-like cysts (round and yellowish intraepidermal formations filled with keratin) and comedo-like openings (chestnut brown-black invaginations, filled with keratin and with well defined borders).<sup>2,3</sup> Although those characteristics can also be observed in papillomatous melanocytic nevi, they are very common in seborrheic keratoses. Other verifiable traits are moth-eaten or jelly borders in plane lesions, and a cerebriform aspect in more papulous ones.

Its diagnosis does not usually present difficulties, although in some situations it can simulate melanoma in the clinical and dermatoscopic examinations.<sup>2</sup> Therefore a histological study is required to confirm the diagnosis in such cases. The article discusses cases that characterize seborrheic keratoses resembling melanoma.

#### Case 1:

A 69-year-old female Asian patient presented an irregular pigmented lesion in the lumbar region, with no other similar lesions on the skin. She could not specify for how long she had had it and did not have a history of melanoma. In the dermato-

## Applied Dermatoscopia

### Authors:

Alessandra Yoradjian<sup>1</sup>  
Natalia Cymrot Cymbalista<sup>2</sup>  
Francisco Macedo Paschoal<sup>3</sup>

<sup>1</sup> Collaborator Physician, Dermatoscopy Ambulatory, Dermatology Department, Faculdade de Medicina do ABC (FMABC) – Santo André – (SP), Brazil

<sup>2</sup> Master in Dermatology, Hospital das Clínicas da Faculdade de Medicina da Universidade de São Paulo (USP) – São Paulo (SP), Brazil

<sup>3</sup> Assistant Professor, Dermatology, Faculdade de Medicina do ABC (FMABC)

### Correspondence:

Dra. Alessandra Yoradjian  
R. Sampaio Viana, 580 – Paraíso  
04004-002 – São Paulo, SP, Brazil  
E-mail: alessandraderma@terra.com.br

Received on: 14/06/2011  
Approved on: 18/06/2011

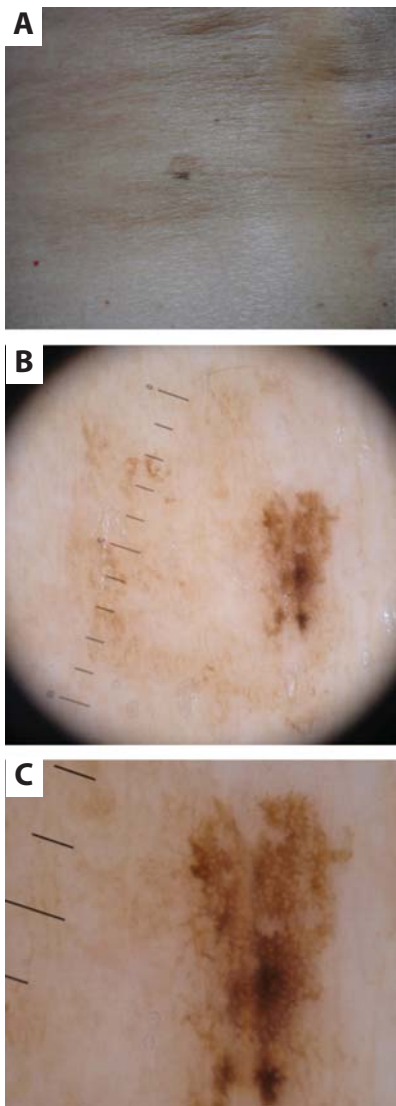
This study was carried out at the Faculdade de Medicina do ABC (FMABC) – Santo André – (SP), Brazil.

Conflicts of interests: none  
Financial support: none

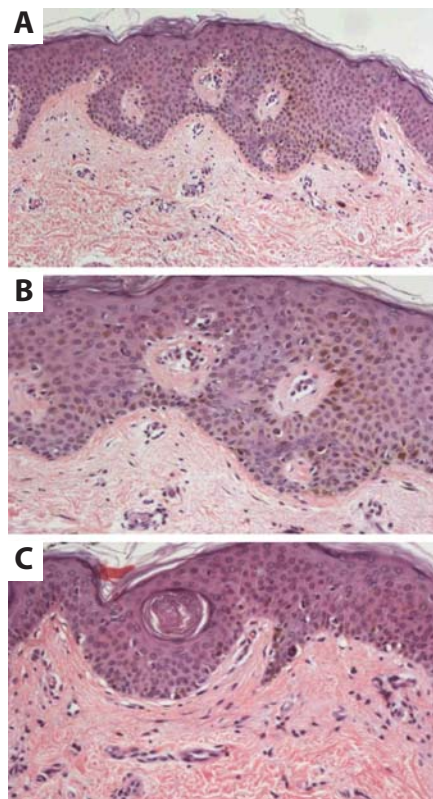
scopic examination, the lesion appeared asymmetric, with pigmentation varying from light to dark brown, forming an amorphous area, with a delicate pigmentary network in most of the lesion and an area of eccentric hyperpigmentation where the pigmentary network was thicker and there were blotches. Due to the possibility of melanoma, an excisional biopsy was performed, with the histopathologic examination results determining that it was a pigmented seborrheic keratosis (Figures 1 and 2).

**Case 2:**

A 63-year-old white female patient presented with a blackened irregular lesion on the back that she noticed three months previously. She described a family history of skin cancer, without specifying the type. In the dermatoscopic examination, the asymmetry of the lesion was clear not only regarding the shape, but also the variability of colors (light brown, dark brown, black, grayish and bluish white). Irregular points, blotches and a bluish-white veil were observed. Due to a strong suspicion of melanoma, a decision was made to carry out an exci-



**Figure 1-**  
**A.** Clinical appearance;  
**B.** Dermatoscopic appearance;  
**C.** Dermatoscopic appearance – details of the eccentric hyperpigmentation area

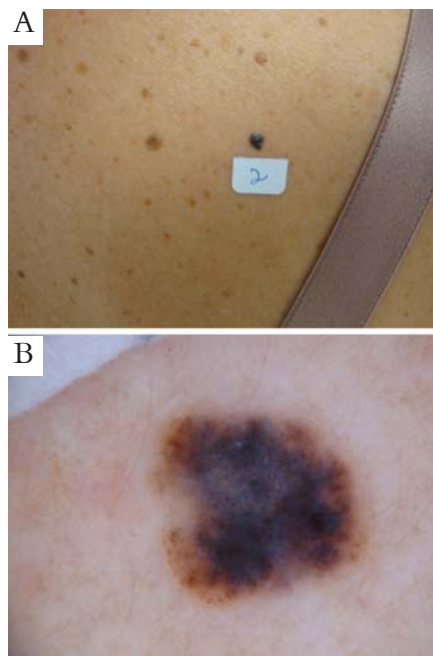


**Figure 2-**  
**A.** Histologic appearance – panoramic view;  
**B.** Histologic appearance – details of the proliferation of basaloid cells area;  
**C.** Histologic appearance – pseudo-horn cysts

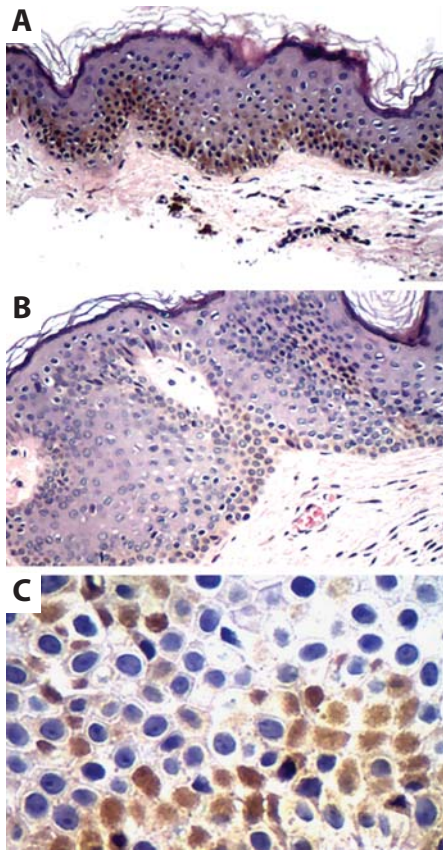
sional biopsy of the lesion. The histological diagnosis was that the lesion was a seborrheic keratosis (Figures 3 and 4).

**COMMENTS**

Dermatoscopy, or microscopy epiluminescence, is a non-invasive and practical examination that emerged a few decades ago as an important subsidiary tool in diagnosing pigmented lesions. This method helps differentiate non-melanocytic and



**Figure 3-**  
**A.** Clinical appearance;  
**B.** Dermatoscopic appearance



**Figure 4-**  
**A.** Histologic appearance – panoramic view;  
**B.** Histologic appearance – proliferation of basaloid cells and pseudo-horn cysts;  
**C.** Histologic appearance – pigmented basaloid cells (detail)

melanocytic lesions (first-level analysis), and can gauge the malignant potential of the latter (second-level analysis). It can increase the accuracy of a diagnosis by 5–30%,<sup>2</sup> compared to a clinical examination alone. However, in certain situations there are difficulties in interpreting the results due to features that get mixed and the subjective nature of the analysis, which could lead to false-positive or false-negative results for malignancy – especially in the case of melanoma.<sup>4</sup>

This article is aimed at illustrating some of those situations, describing seborrheic keratosis cases that resemble melanoma, both clinically and dermoscopically.

First-level analysis is the most important in identifying seborrheic keratosis. If the lesion is mistakenly found to be melanocytic, there is a high risk of misinterpretation in the second-level analysis, which can often lead to an erroneous classification of malignancy.<sup>2</sup>

The main dermoscopic features observed in seborrheic keratoses are milium-like cysts and comedo-like openings (initial algorithm proposed by Stolz and colleagues), with well defined moth-eaten or jelly borders. Nonetheless, other features, such as hairpin vessels, pigmentary network-like structures (usually more prominent, thicker and heterogeneous than the classic pigmentary network of melanocytic lesions), blotches, points, crusts, fissures (cerebriform aspect), fingerprint-like, whitish veil, in addition to a possible variation in colors (yellow, black, dark brown, light brown, grayish-blue), have been already identified.<sup>3,5</sup> The observation of those additional features can reduce diagnostic mistakes considerably, further improving the accuracy of this valuable dermatologic resource.<sup>2</sup> ●

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