Regional Conference of Dermatology (Asian-Australasian)
incorporating the
6th Annual Meeting of the
Asian Academy of Dermatology and Venereology

Theme:
Enhancing Best Practice in
Clinical and Cosmetic Dermatology

Date: 9th to 12th April 2014
Venue: Furama Convention Centre & Hotel
Danang, Vietnam

ABSTRACT BOOK
SEBORRHEIC KERATOSIS MIMICKING BASAL CELL CARCINOMA: FIVE CASES REPORTS

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INTRODUCTION
Seborrhoeic keratoses are benign cutaneous neoplasms that occur most common in adults and middle-aged, often found in any area except palms and soles of the feet, have a tendency to appear facial area, chest and back. Seborrheic keratosis has well demarcated and slightly raised lesions with gray brown to black color, can be covered with oily scale. Most lesion diameter is less than a centimeter or more, but the larger variants. The differential diagnosed of seborrheic keratosis is basal cell carcinoma, melanoma, and nevus pigmentosus.

PATIENTS, MATERIALS AND METHODS
We reported five cases with initial diagnose of basal cell carcinoma. From the results of histopathology examination in all cases are seborrhoeic keratosis. Patient treated with excision.

RESULTS
All cases treated with excision and showing significant improvement.

DISCUSSION
Seborrhoeic keratoses are benign skin tumors that has similar clinical manifestation with basal cell carcinoma. Histopathology examination need to determine a definitive diagnosis optional which showed hyperkeratosisis, acanthosis, papillomatosis accompanied by a keratin-filled invagination and horn cyst. Therapeutic modalities are curettage, excision and cryosurgery. The excision that preformed in all 5 cases has high cure rate and minimal scar risk.

KEYWORDS
Basal cell carcinoma, histopathological, seborrhoeic keratosis, surgical excision.
SEBORRHEIC KERATOSIS PRESENTING LIKE BASAL CELL CARCINOMA

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Abstract

Seborrheic keratoses are benign skin tumors appear most at an advanced age, in about 20% of the population and is usually absent or rare in people at middle age. Seborrheic keratoses can appear in many forms, can be single or multiple. The lesions are well-demarcated, round or oval-shaped, the color can resemble skin color, brown or black, and appear to attach to the skin. The exact cause of seborrheic keratosis is not well understood. The genetic factors, sun exposure and infection are the potential causes. There are several available treatment methods including curettage, surgical excision, electrodessication, cryotherapy, and ablative laser.

A case of seborrheic keratosis is reported in a 63-years-old woman. Lesion is located in left nose side with clinical features that included hyperpigmented nodule with verrucous surface, measuring 1.5 x 1.5 x 1 cm with tender and immobile consistency. Treatment is by surgical excision with satisfactory outcome.

Keywords: Surgical excision, Basal cell carcinoma, Seborrheic keratosis

Introduction

Seborrheic keratoses are benign cutaneous neoplasms most commonly found in adult and middle-aged patients, frequently found in any body areas except the palm and sole, with preponderance in face, chest and back. Seborrheic keratoses are well-demarcated and lesions are slightly raised with brown-gray to black color, can be covered by shiny squamous. Most of the lesions have diameter not more than one centimeters, but with larger variant\(^{(1,4)}\).

In some studies in Australia, seborrheic keratosis lesions were identified in 30% of subjects under 30 years-old and increased to 100% in subjects above 50-years-old. The overall prevalence in a population in United Kingdom was found to slightly lower with lesions identified at about 75% of subjects at age of 70.\(^{(2,5)}\) This condition generally affects white race, with equal proportion between male and female. It has been reported that 80-100% of males from Caucasoid race at age of 35 with white skin have at least one seborrheic keratosis, whereas those at age of 51-75 had at least 23 lesions in each individu.\(^{(5)}\)
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Introduction

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The cause of seborrheic keratosis is not well understood. Genetic factor, sun exposure, and infection are the possible causes. Most of the individuals with seborrheic keratosis have the same history in their family. The occurrence of seborrheic keratosis has also been associated to melanocyte derived growth factors except the increased TNF-α and endothelin converting enzymes expression. These two last factors relate to increased expression of keratinocyte melanogene, endothelin-1, resulting in hyperpigmentation in seborrheic keratosis.\(^{(6-9)}\)

There are some histological forms, sometimes clinically different, in seborrheic keratosis, namely common seborrheic, keratosis, reticulated seborrheic keratosis, stucco keratosis, clonal seborrheic keratosis, irritated seborrheic keratosis, seborrheic keratosis with squamous atypia, melanocanthoma, dermatosis papulosa nigra, the sign of Leser-Trelat. All of these seborrheic keratosis forms have hyperkeratosis, acanthosis and papillomatosis. In seborrheic keratosis cases, pseudohorn cyst is considered as the most important characteristic.\(^{(2,6,7,10,11)}\)

Management of seborrheic keratosis is rarely necessary. Cleaning with cauterization and excision are usually effective.\(^{(2)}\) Excision is the appropriate therapy for most of the atypical or inflammatory seborrheic keratosis.\(^{(12)}\)

The following is a report of a seborrheic keratosis case occurred in left nose side of a 63-years-old woman. The excision procedure taken provided good outcome.

**Case Report**

A 63-year-old women with medical record number 617640 presented to polyclinic of Dermatology and Venereology of Ibnu Sina hospital with complaint of the emergence of blackish protrusion on her left nose side since last 5 years. The protrusion was initially small in size and gradually increased in size. The protrusion was painless, not pruritic, and not easily bleeding. The lesion have not been treated before. There was no other similar condition known in her family. There was no allergy history.

The general condition of the patient was good. Dermatologic state indicated the presence of skin lesion at nasal-mid region with efflorescence in the form of hyperpigmented module with verrucous surface, measuring 1.5 x 1.5 x 1 cm with soft and immobile consistency. Patient was diagnosed as basal cell carcinoma with differential diagnosis of seborrheic keratosis.
Figure 1: Hyperpigmented nodule with verrucous surface at nasal mid region, measuring 1.5 x 1.5 x 1 cm with tender and immobile consistency.

Patient was managed with excision and administered with simlev® 500 mg b.i.d and paracetamol 500 mg t.i.d in tablet.

Figure 2: Excision procedure on lesion
Lesion excision procedure:

Patient was placed on operating table in supine position.

A-B: Local anesthesia was placed around the lesion using Pehacain® 2%. Ellipse marker was med beyond the tumor borders on the area to be excised. The operating area was disinfected using povidone iodine 10 % and the operation field was covered with sterile kerchief.

C-E: Incision was performed around the ellipse marker using scalpel and pinset.

F-H: The release of tissues under and around the lesion. Any existing bleeding was identified and controlled accordingly. The surgery wound was closed by interrupting suture with vicril 5.0.

- Lesion was then cleaned with povidone iodine 10% and NaCl 0.9% and covered with sofratulle® and sterile gauze. The excised lesion was marked in its four edges using string and then put into formalin 10% for histopathological evaluation.
- Operation done.

Histopatological evaluation results (P.13.2720) indicated hyperplastic, hyperkeratotic epidermis with intraepidermal horn cyst. In the upper dermis were solid inflammatory cells pollens. There was no malignant basaloïd cells in this preparation. The conclusion was seborrhoeic keratosis with medium edge still containing tumor cells.

Figure 3: Histopathology a. Hyperplastic, hyperkeratotic epidermis is shown with intraepidermal horn cyst. In upper dermis there is a solid inflammatory cells pollens in dermis.
According to anamnesis, physical evaluation and supporting examinations, patient was finally diagnosed with seborrheic keratosis.

Follow-up visit at day 7 showed a drying up lesion, erythema (-), madidans (-), pain (-), pruritus(-). Alternating aff hecting was performed, and the administered with ciprofloxacin 500 mg b.i.d and cester® tablets.d.d. Patient was suggested to have a follow-up visit in dermatology and venereology polyclinic.

![Figure 4: Follow-up visit at day 7; A. Drying up suture, erythema(-), madidans(-). B. After the alternating aff hecting.](image)

Follow-up visit at day 11 showed a dried up suture, lesion was recovering, erythema (-), madidans (-), pain (-), pruritus (-), scar (+). Aff hecting was performed completely, and therapy was continued.

![Figure 5: Follow-up visit at day 11; Complete aff hecting was performed. Recovery was observed, lesion drying up, erythema (-), madidans (-), scar (+)](image)
Patient was followed up to her home at week 7 and the suture was dried up, lesion was healed, and there was scar.

![Image](image_url)

Figure 6: Follow-up after 7 weeks; Lesion is recovered, Scar(+)

**Discussion**

The presented case is a 63-year-old women which is in accordance to literature that seborrheic keratoses are frequently observed in individu aged 40 or above, and generally increased with age.\(^5\) Patient complained the emergence of blackish protrusion measuring 1.5 x 1.5 x 1 cm on her left nose side since last 5 years. The protrusion was initially small in size but gradually increased in its size. This is in accordance to literature the seborrheic keratosis has multiple lesions and presented as papules or plaques with gray-brown, yellowish-brown or brown to black color, well-demarcated, irregular, plain, varied sizes from 1 mm to several centimeters, but rarely exceeds 3 centimeters. The commonly affected areas are head skin, face, neck, chest, back, and extremities.\(^1,2,4-8,10\)

The histopathological features of seborrheic keratosis consist of hyperkeratosis, acanthosis, papillomatosis accompanied with invagination full of keratin and small cysts (horny cysts) as the characteristic features\(^2,4,6-7\). These are compatible to histopathological features in the present case where hyperplasia, hyperkeratosi of epidermis with intraepidermal and in upper dermis there were solid inflammatory cells pollens.

In this case the differential diagnosis is basal cell carcinoma (BCC). BCC usually occurs in head and neck region exposed to sun light, as well is in any body area. About 75% of basal cell carcinoma occur in head an neck area, 57% of lesions occur in nose area, and
17.7% in other areas in face, 10% in trunk area which is not exposed to sun light, but the BCC can also occur in area relatively protected from sun light. BCC occurs rarely in patient aged 40 years-old, more often in patient above 60. The clinical manifestations included translucent surface, ulceration, telangiectasia, with rounded margins.\(^\text{13-15}\)

Histopathologic characteristics include the presence of basaloid cells nests and squamous cells, arranged in edges forming palisade structure. Basaloid cells have large nucleus with relatively few cytoplasm.\(^\text{13,16}\)

There are several variants of histopathological features of seborrheic keratosis including the common, acanthotic, hyperkeratotic or stuci, adenoid or reticulated, clonal, irritated and melanoacanthoma. In common type the lesion is in the form of verrucous papule attaching classically with pseudohorn cysts, hyperkeratosis, achantosis, and papillomatosis as the predominating pathological features. Seborrheic keratosis generally emerge only as well-demarcated brown trapped papules with granular surface, with brown or dark brown color although the color can be varied from white to black. In a study by Rajesh et. al., 60% of seborrheic keratoses were common type.\(^\text{6,10}\) In stucco keratosis, the lesion is in the form of verrucous papule with white or white-gray color measuring several millimeters, often in large number (100 or more) on areas exposed to sun light (lower extensor surface and foot, dorsal of hand and foot), whereas the irritated seborrheic keratosis type is a seborrheic keratosis that has been subjected to mechanical or chemical irritation and melanoacanthoma. The acanthotic type consists of large column or sheet of basaloid cells with horn cyst intervention. The reticulated type (adenoid) is in the form of thin sheet of pigmented basaloid cells covering the horn cyst. This variant often develops from actinic lentigo. Clonal seborrheic keratoses have an intraepidermal basaloid cells nest.\(^\text{4,6,10}\) According to these characteristics, the presented patient was belong to common seborrheic keratosis.

Seborrheic keratoses have indications that are often disturbing cosmetically and treatment is necessary. Several of the treatment modalities can be choosen from to treat seborrheic keratosis. There are some effective treatment method, but the most commonly used are cryosurgery, curettage and excision. The advantages of this procedure included the high curability and can minimize scar risk.\(^\text{6,17}\) Management of the presented patient used excision technique with minimal scar.

Common complications of destructing treatment method include scar, pigmentation alteration, incomplete lesion removal or recurrence, and even several treatments are needed to
confirm the eradication of initial lesion completely.\(^6\) In this present patient, the complication of the procedure was the presence of minimal scar.

References


