

A hyperkeratotic, clonal seborrheic keratosis accompanied by nodulocystic basal cell carcinoma

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CLINICAL PRESENTATION

A 59-year-old man with the 7-year history of an asymptomatic brown plaque located on the upper aspect of his left arm noticed a dark-blue pigmentation starting to appear in mentioned lesion several months previously. Clinical examination revealed an asymmetrical, partially raised pigmented warty plaque measuring 22 mm, with a 2-mm dark-blue papule in an eccentric localization within the plaque (Fig 1).



Fig 1. Seborrheic keratosis (SK)/basal cell carcinoma (BCC), clinical image. An asymmetrical brown plaque with a 2-mm dark-blue, round papule.

DERMOSCOPIC APPEARANCE

Dermoscopy (DermLite Photo; 3Gen LLC, Dana Point, CA) revealed the criteria of 2 different lesion types. The main lesion presented with a cobblestone global pattern, multiple brown dots, and sharp border demarcation (Fig 2). The new, smaller lesion presented with bluish areas of variable sizes and shapes placed on a dark-blue background.

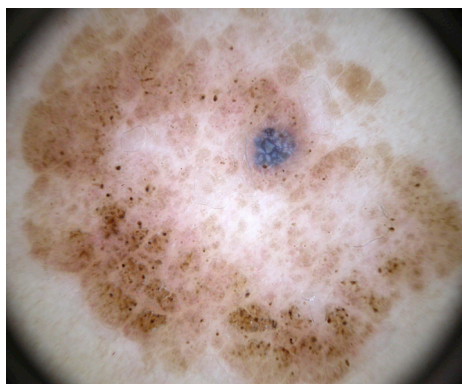


Fig 2. Seborrheic keratosis/basal cell carcinoma, dermoscopic image. Note the absence of typical features of SK such as comedo-like openings, milia-like cysts, and hairpin vessels in presented clonal SK and the absence of typical features of BCC in presented nodulocystic BCC.

HISTOPATHOLOGIC DIAGNOSIS

Histologic examination confirmed that the lesion was a nodulocystic basal cell carcinoma arising below the hyperkeratotic, clonal seborrheic keratosis (Fig 3).

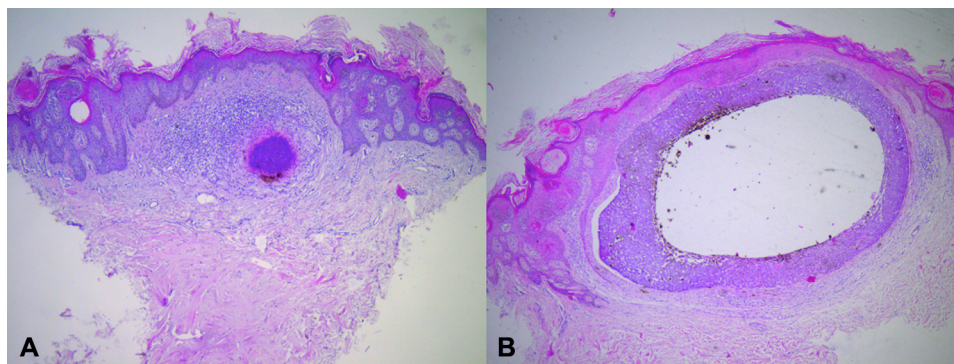


Fig 3. Seborrheic keratosis/basal cell carcinoma, histologic image. **A**, The epidermis shows the hyperkeratosis, papillomatosis, acanthosis, and intraepidermal nests of basaloid cells resembling Borst-Jadassohn phenomenon. In the middle dermis is a solid nodular structure composed of bright oval cells with pigment at the periphery of the nodule and lymphocytic infiltrate. **B**, Cross-section of the middle part of the nodule shows the cyst surrounded by basaloid cells, and presence of semilunar lacuna. No direct connection between the 2 histologically distinct lesions was observed. Therefore, the final diagnosis was concomitant hyperkeratotic, clonal SK with underlying nodulocystic BCC. (**A** and **B**, Hematoxylin-eosin stain; original magnification: $\times 40$.)

KEY MESSAGE

Little is known about dermoscopy of rare, clonal variant of seborrheic keratosis. The recent study confirmed the previous findings reported in the literature: that diagnosis of clonal seborrheic keratosis might be considered when milia-like cysts and blue globules are found in the context of a sharply demarcated lesion.¹ An important message to be gleaned from this report is that clonal seborrheic keratosis and nodulocystic BCC may have one more dermoscopic face. The clonal seborrheic keratosis may present with cobblestone pattern and multiple brown dots in absence of milia-like cysts, whereas nodulocystic BCC may present with dark-blue pigmentation only, which would be expected in pigmented not in cystic variant of BCC.

REFERENCE

1. Longo C, Zalaudek I, Moscarella E, et al. Clonal seborrheic keratosis: dermoscopic and confocal microscopy characterization. *J Eur Acad Dermatol Venereol*. 2014;28:1397-1400.