Seborrheic keratosis of the breast mimicking melanoma

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Abstract
Seborrheic keratosis is a common skin lesion that can usually be recognized either clinically or dermoscopically. However, seborrheic keratosis with atypical clinical and dermoscopy presentation are increasingly reported. The main objective in differential diagnosis is to discriminate seborrheic keratosis from malignant conditions, and especially melanoma, in order to determine correct treatment pathways as early as possible. We report a case of a 66-year-old woman with an atypical clinically and dermoscopy pigment- ed lesion of the breast, mimicking melanoma.

Introduction
Seborrheic Keratosis is one of the most commonly observed benign skin tumours in everyday clinical practice. In their typical form, it appears as variably pigmented patches and nodules, often affecting elderly people [1]. Despite an often unsightly appearance which can be frightening for the patient, a dermoscopic examination usually allows a clear-cut diagnosis of the disease with typical features [2]. However, Seborrheic keratosis with atypical dermoscopy presentation are increasingly reported. These lesions sometimes mimic melanoma, thus complicating the differential diagnosis [3]. We aim to present a non-typical case of seborrheic keratosis with atypical dermoscopy presentation, observed as a pigmented lesion of the breast mimicking melanoma.

Case presentation
A 66-year-old woman, with 6-year history of an ischemic cerebral stroke complicated by left hemiplegia. The patient’s medical and family history of cutaneous diseases was negative.

She presented 8 months’ history of an asymptomatic bleeding pigmented lesion of the right breast. Dermatological examination revealed a 3 cm black, multilobed, pedicled tumor, firm in consistency with well-defined borders on erythematous background of the right breast (Figure 1). Dermoscopy showed heterogeneous pigmentation, linear vessels and brown globules (Figure 2) with the absence of comedo-like openings. From the clinical and dermoscopic point of view the lesion appeared suspicious. The diagnosis of melanoma was strongly being made.

through the history, clinical examination, dermoscopic features and
and the rapid growth of the tumor. A total excision of the lesion
was performed. To our surprise, histopathological examination
showed exophytic proliferation of epidermal cells. The lesion ex-
hibited papillomatosis, hyperparakeratinization, acanthosis and
deep, keratin-filled invaginations. Keratotic invaginations with
intraepithelial keratin cysts were present. Melanin pigmenta-
tion was observed in the basal layer. The dermis exhibited colla-
gen fibers, blood vessels and moderate inflammatory infiltrate
(Figures 3, 4). At 7 months of decline, no recurrence was noted.

Figure 1: A 3 cm black multilobed pedicled tumor of the right
breast.

Figure 2: Dermoscopy showing a heterogeneous pigmentation,
linear vessels and brown globules.

Figure 3: Histologic findings: pseudohorn cysts in the epidermis
opened to the surface of the lesion and intraepidermal cysts.

Figure 4: Histologic findings: papillomatous surface of the epi-
dermis with enlarged capillaries of the dermal papillae.

Discussion

Seborrheic keratosis is a common benign tumor, the diagnosis is, in
general, a clinical one.

It appears as variably pigmented patches and nodules, often af-
fected elderly people [1]. But in some cases, the differential diagnosis
between pigmented seborrheic keratosis and malignant melanoma
is difficult [4]. Although, Dermoscopy is a non-invasive helpful tool
in diagnosis of seborrheic keratosis [5]. Typical dermoscopic features
that we commonly use to identify seborrheic keratosis, were system-
amically described and included in a dermoscopic algorithm in 2003 by
Argenziano et al, such as multiple milia-like cysts, comedo-like open-
ings, fissures, finger-print structures and sharply demarcated borders
[2]. A series of additional dermoscopic criteria to increase diagnostic
accuracy, underlining fissures, hairpin vessels, sharp demarcation and
moth-eaten borders were proposed. Later, Scope and al observed that
some typically melanocytic dermoscopic features, such as pigmented
network, aggregated globules, streaks and homogeneous blue colour,
were also present in seborrheic keratosis and other non-
melanocytic lesions [3]. As a consequence, when characteristics features of sebor-
rheic keratosis are observed at dermoscopy, a differential diagnosis is
simplified. In our case, we believe that the original misdiagnosis result-
ed because of the absence of this findings at dermoscopy. Reflectance
confocal microscopy is also an optimal non-invasive examination for
early differential diagnosis of seborrheic keratosis with atypical der-
moscopy presentations. Therefore, It may be able to assist in differ-
ential diagnosis and avoid unnecessary excisions [3]. Histopathology
should remain mandatory for seborrheic keratosis with atypical der-
moscopy and without a clear differentiation from other malignancies
at dermoscopy [6]. The management of these atypical seborrheic ker-
atosis remains undefined, often requiring a final excision of the lesion
to reach a correct diagnosis [7]. To complicate the picture, melanomas
mimicking seborrheic keratosis have also been reported [8]. Interest-
ingly, the current case shows that seborrheic keratosis can present a
challenging clinical appearance, and even expert dermatologists can
misdiagnose these difficult cases.

Conclusion

We showed one of the rare clinical and dermoscopical pictures of
seborrheic keratosis which suggested melanoma. A histopathological
examination is crucial in confirming the diagnosis.

References

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