

Case Report

Seborrhagic keratitis: a benign pigmented skin lesion management

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ABSTRACT

Seborrhoeic keratosis are formed from the basal layer of epidermal cells and contain melanocytes. Many terms such as senile wart, melanoacanthoma, basal cell papilloma, senile keratosis and seborrhoeic wart have been applied, but seborrhoeic keratosis is the most widely accepted term. In our case a 50-year-old female presented to the surgery OPD with a painless pigmented skin lesion 2.5cm lateral to the left lateral canthus and 1cm below the hairline of size of 4*4cm. Pigmented lesion was from last 8 years and slowly progressive in nature and was not associated with any co morbid conditions. On clinical evaluation the clinical diagnosis of epidermal nevus was given and an excisional biopsy with rhomboid flap placement was performed and the tissue was sent for histopathological examination. Post operative period was uneventful and the histopathology report states the seborrhoeic keratosis. Hence, lesions for which the diagnosis is uncertain, based on the history and gross examination, should be biopsied for histopathologic examination to rule out malignancy.

Keywords: Benign pigmented skin lesion, BCC, Epidermal Nevus, Melanoma, Seborrhoeic keratosis, Verruca vulgaris

INTRODUCTION

Seborrhoeic keratosis vary from macular to soft, exrescent, warty lesions, which are often pigmented and hyperkeratotic. They are formed from the basal layer of epidermal cells and contain melanocytes.¹ Seborrhoeic keratosis are common, benign, pigmented epidermal tumors.² These usually develop after the age of 50 years although occasionally, seen in young adulthood without any sexual predilection. The common site of involvement includes the trunk, particularly the interscapular area, sides of the neck, the face and the arms. The etiology is not well-known, although heredity, sunlight and human papilloma virus (HPV) have been suggested as risk factors. Recent genetic studies have suggested that somatic mutations in Fibroblast GROWTH Factor Receptor 3 (FGFR3) gene are important in the development of these lesions.³ Histologic examination is

a valuable diagnostic tool, frequently affecting treatment decisions.

CASE REPORT

A 50-year-old female presented to the surgery OPD with a painless pigmented skin lesion 2.5cm lateral to the left lateral canthus and 1cm below the hairline of size of 4*4cm. Pigmented lesion was from last 8 years and slowly progressive in nature and was not associated with any co morbid conditions. On clinical evaluation, a single, well-circumscribed brownish black nodular mass was present about 2.5cm lateral to the left canthus and 1cm below the hairline (Figure 1).

The mass measured about 4*4cm in size and the overlying skin was rough and fissured with minute nodular surface projections. On palpation, the mass was

firm in consistency with no tenderness or discharge. A clinical diagnosis of epidermal nevus was given and an excisional biopsy with rhomboid flap placement was performed (Figure 2, Figure 3) and the tissue was sent for histopathological examination. Post-operative period was uneventful (Figure 4) and the histopathology report states the seborrheic keratosis.



Figure 1: Brownish black nodular mass lateral to left canthus and below the hairline.



Figure 2: Excision of the pigmented nodular mass.



Figure 2: Excision of the pigmented nodular mass and rhomboid flap is created.



Figure 4: Post-operative wound after excision of lesion and placement of rhomboid flap.

DISCUSSION

Seborrheic keratosis are common, benign, pigmented epidermal tumors.² These usually develop after the age of 50 years although occasionally, seen in young adulthood without any sexual predilection. The common site of involvement includes the trunk, particularly the interscapular area, sides of the neck, the face and the arms. The etiology is not well-known, although heredity, sunlight and human papilloma virus (HPV) have been suggested as risk factors. Recent genetic studies have suggested that somatic mutations in Fibroblast Growth Factor Receptor 3 (FGFR3) gene are important in the development of these lesions.³

Medical management includes ammonium lactate and alpha hydroxy acids. Superficial lesions can be treated by carefully applying pure trichloroacetic acid and repeating if the full thickness is not removed on the first treatment. Topical treatment with tazarotene cream 0.1% shows clinical improvement in Seborrheic keratosis.

But the pigmented subtype may be clinically confused with other pigmented lesions, such as malignant melanoma, pigmented basal cell carcinoma or melanocytic nevus.⁴ Therefore, lesions for which the diagnosis is uncertain, based on the history and gross examination, should be biopsied for histopathologic examination to rule out malignancy.⁵

So, surgical management such as excision biopsy will be required for the better outcome. Other methods are cryosurgery, electrodissection, shave excision, or curettage.⁶

So, different studies we conducted which favours the excision biopsy of the lesion rather than conservative management.

Luba MC et al, concluded in their study that benign skin tumors are commonly seen by family physicians. The

ability to properly diagnose and treat common benign tumors and to distinguish them from malignant lesions is a vital skill for all family physicians. Any lesions for which the diagnosis is uncertain, based on the history and gross examination, should be biopsied for histopathologic examination to rule out malignancy.⁵

Phulari RGS et al, gives their valuable conclusion on a case study that Seborrheic keratoses are benign lesions. They generally are only of aesthetic concern to the patient. Some lesions may be bothersome because of pruritus and are usually treated for this reason. It may clinically mimic a malignant tumor, thus they are usually biopsied to exclude other tumors.⁷

Tsvetan Tsvetano in his case performed the excision biopsy and concluded that in medicine, early detection and accurate diagnosis of the seborrheic keratoses is of paramount importance for successful treatment. Therefore, the doctor must have knowledge of the biological and histological behavior of seborrheic keratoses and her frequency to ensure early detection, accurate diagnosis and proper treatment.⁸

Urmila Nischal and his team in an article for general skin lesions concluded that skin biopsy is a simple procedure that has a great diagnostic value. Knowledge of practical aspects of this technique along with awareness of complications arising from skin biopsy and its management takes a dermatologist a long way in his dermatology practice in terms of arriving at a diagnosis or providing new and more information regarding the disease.⁹

Luen KK et al, in his study stated that it has been proven by recent molecular studies that seborrheic keratosis is true neoplasia rather than a mere epidermal hyperplasia, and various authors have reported several cases of concomitant malignancy arising from seborrheic keratosis. Plastic surgeon expertise is often required when faced with an extensive lesion, requiring reconstructive procedures to preserve good aesthetic and functional outcomes.¹⁰

In this study the pigmented lesion was also excised for both the curative and diagnostic purposes with the reconstruction of iatrogenic defect created due to excision by a rhomboid flap.

CONCLUSION

Surgical excision with reconstruction is a relatively better treatment modality in case of diagnostic dilemma for pigmented skin lesion.

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