



RESEARCH ARTICLE

ANATOMOCLINICAL CONFRONTATION BETWEEN MELANOMA, SOLAR LENTIGO AND SEBORRHEIC KERATOSIS: A CASE REPORT

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Abstract

The primary diagnosis in case of a rapidly developing facipigmented lesion in an elderly patient is Dubreuilh's melanoma . This case report is highlighting the issue of anatomoclinical confrontation between a clinically suspected melanoma and a pathologically confirmed solar lentigo and seborrheic keratosis.

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Introduction:-

Morocco is a northern african country with a subtropical climate where the ultraviolet light index ranges between 6 and 7 , and the predominant Fitzpatrick phototypes are III (darker white skin that tans after initial burn) and IV(light brown skin that rarely burns and tans easily)

The male moroccan population does not abide by the rules of sun protection , mainly sunscreen application on sun exposed areas especially the face. Therefore , chronic sun exposure and other ultraviolet radiation induced skin lesions are mainly common in the male population .

Melanoma is the deadliest form of skin cancer , it has increased by 50 percent to over 287000 cases per year over the last decade . According to the 2020 Melanoma Skin Cancer Report , its incidence in Morocco ranged between 0.58 and 1.4 as stated in the worldwide age standardized annual incidence rate by geography . In spite of this fact , it's still preventable thanks to sunprotection , and treatable if detected early , therefore , any hyperpigmented lesion on the skin should be suspected primarily as melanoma .knowing that benign lesions such as seborrheic keratosis can clinically resemble melanoma.

Solar lentigo , which is linked to lifetime sun exposure ,has a relative risk (RR) of 2.96 as a precancerous lesion leading to melanoma , intermittent sunburn is an independant risk factor (RR 2.03) , on the other hand , chronic sun exposure is a protective factor against melanoma (RR 0.95) .

Seborrheic keratosis are skin growths that appear after the age of 30 years in genetically susceptible individuals , people with darker skin are prone to developping multiple seborrheic keratoses growths on their cheekbones , this condition is called dermatosis papulosa nigra .

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Case Report:

A 83 year old moroccan male patient , born and raised in the suburbs of Tangier , Morocco , who previously worked as a farmer with a history of chronic sun exposure with sun induced hyperpigmentation , and a few intermittent sunburns before the age of 20 years , was admitted to the plastic surgery unit in Kortobi Hospital of Tangier , complaining of a 5 cm mole located in the right cheek , precisely the right zygomatic region , extending partly to the right buccal region , this lesion appeared twelve months prior to the admission and rapidly increased in size during this time frame. It was an inhomogenous dark brown lesion with uneven borders , a rough surface and and an excentric lump that measured 1 cm in diameter , its major axis measuring 5 cm and had a « stuck on » appearance , mobile relative to the surrounding tissues , and surrounded by other similar but smaller in size (less than 1cm) lesions dispersed in the frontal and right temporal region . No palpable lymphadenopathy was detected in the regional lymph node stations nor the remote lymph node areas .



Figure1.2:- Dark brown lesion with uneven borders , rough surface and and excentric lump in the right zygomatic region extending to the right buccal region.



Figure 2:- left profile showing sun damage.

The dermatological assessment emphasized a layer of an extended irregular invasive pigmented proliferation , measuring approximately 5 cm in diameter with undefinable borders , the dermoscopy highlighted some features primarily in favour of a Dubreuilh melanoma , namely blue white veil , multiple brown dots invading the pilosebaceous units , double circle images and signet ring cells .

An initial biopsy was conducted subsequently , pointing up the absence of histological signs of malignancy , hyperorthokeratotic epidermis , basal layer hyperpigmentation , and the presence of collagen and elastin fibers dystrophy and a moderate inflammatory infiltrate made of lymphocytic and plasmocytic cells in the superficial dermis , inferring a solar lentigo .

The surgical resection was delayed for two weeks due to a bacterial pneumonia that contraindicated general anesthesia , it was performed as soon as the infection subsided thanks to successful antibiotic therapy . It consisted of a wide excision under general anesthesia using a 1 cm safety margin , the loss of substance was covered by a full thickness graft , the donor site was the homolateral supraclavicular area . The surgical outcomes were simple .

The final anatomo pathological report of the surgical sample mentioned an exophytic benign tumor , with papillomatous acanthotic epidermis characterized by a jagged (sawtooth) appearance containing horn cysts , epidermal proliferating cells with a basaloid appearance , the epidermis was surmounted by a loose lamellar orthokeratotic hyperkeratosisInvaginations forming keratin-filled pseudocystsExtended pigmentary incontinenceDense inflammatory infiltrate made of lymphocytic and plasmocytic cells in the superficial dermis , and the absence of any malignancy histological signs



Figure 3:- 10 Days Post Surgery.



Figure 4:- Donor site incision.

The patient was examined over the course of several appointments during 3 months in order to notice any eventual relapse , no recurring abnormality was seen on the graft , its borders nor the surrounding facial skin .

Discussion:-

Clinically , the predominant method of distinguishing between benign and malignant skin lesions is by the shape , borders, size , color and evolution rate. An uneven shape , irregular borders , a diameter greater than 1 cm , inhomogenous color , are clinical features of cutaneous melanoma. On the other hand , a « stuck on » appearance is in favour of a seborrheic keratosis. Seborrheic keratoses may arise within solar lentigo , this results in localised thickening and change in texture within the lentigo.

The patient had painful sunburns before the age of 20 years , which is a risk factor for melanoma , adding up to the chronic sun exposure which is considered a protecting factor from melanoma , and a risk factor for other lesions .

Melanoma or lentigo maligna Appears on chronically sun damaged skin (predominantly head and neck) , Pigmented macule or patch with poorly defined borders. Dermoscopically , its features are Polygons/rhomboids/zig-zag pattern (angulated lines) , Annular-granular pattern , Asymmetric pigmented follicular openings , Circle within a circle. As for solar lentigo , the lesions are Multiple , Brown papule/plaque , Darker areas can be elevated or verrucous , dermoscopic features are Moath-eaten borders , Pseudonetwork , Comedo-like openings, Diffuse opaque-brown pigmentation , Lightbrown fingerprint-like structures , Milia-like cysts. Seborrheic keratosis Appears frequently on the torso and face , Multiple lesions , Sharply circumscribed brown-to black papules/plaques , it may have verrucous/rough texture , on dermoscopic examination it appears as Milia-like cysts with Comedo-like openings , Hairpin vessels , Sharp demarcation and moth-eaten borders , Fat fingers. It's important to take notice that dermoscopy is an operator dependant examination. In some cases, there is a morphological overlap between actinic lentigo and seborrheic keratoses in the anatomopathological study

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