

Challenging clinical diagnosis of 2 lesions on the back: dermoscopy gives the clue

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Introduction

A 78-year-old man presented with 2 asymptomatic lesions on the back (discovered by a family member a few days earlier) of unknown time of appearance.

Case Presentation

Examination revealed 2 pink macules approximately 2 cm in diameter with sharp edges, located in the right dorsal and central lumbar areas (Figure 1).

Polarized light dermoscopy of the upper macule revealed red-milky areas, punctiform vessels, irregular linear vessels, and a small area with negative pigment network with gray-brown spots (Figure 2). Similar examination of the lumbar lesion revealed shiny, whitish blotches over a whitish-pink background, shiny white streaks or chrysalis, and a number of fine, short, and isolated telangiectasias (Figure 3).

Both lesions were excised. A histological diagnosis of superficial melanoma with a 0.3 mm Breslow thickness was reached for the upper lesion, and a diagnosis of superficial basal cell carcinoma (BCC) was made for the lumbar lesion.

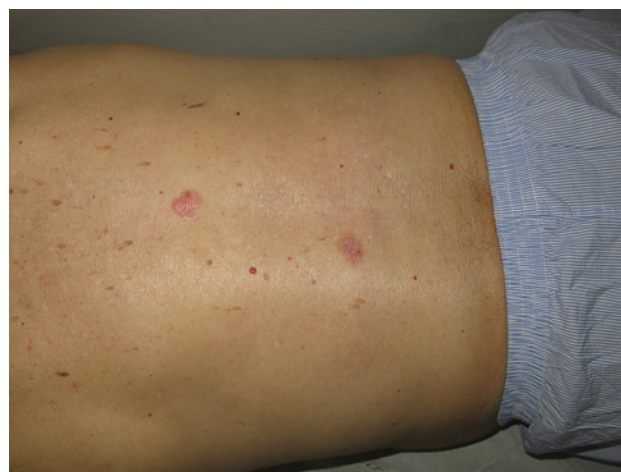


Figure 1. Two pink macular lesions on the patient's back. [Copyright: ©2018 Campos-Muñoz et al.]

Clinically, both lesions appeared to be very similar and required dermoscopy for diagnoses to be reached.

In such nonpigmented lesions, the morphology and distribution of the vasculature can offer diagnostic clues [1]. Punctiform or pinhead vessels are characteristic of melanoma

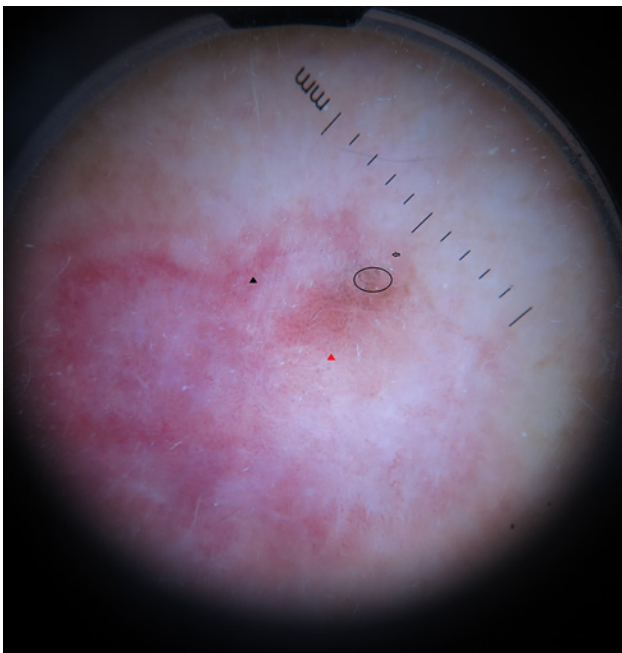


Figure 2. Upper lesion. Note the irregularly distributed punctiform vessels (black triangle and red triangle), gray-brown spots (black circle), and asymmetrically distributed negative pigment network (black arrow). [Copyright: ©2018 Campos-Muñoz et al.]

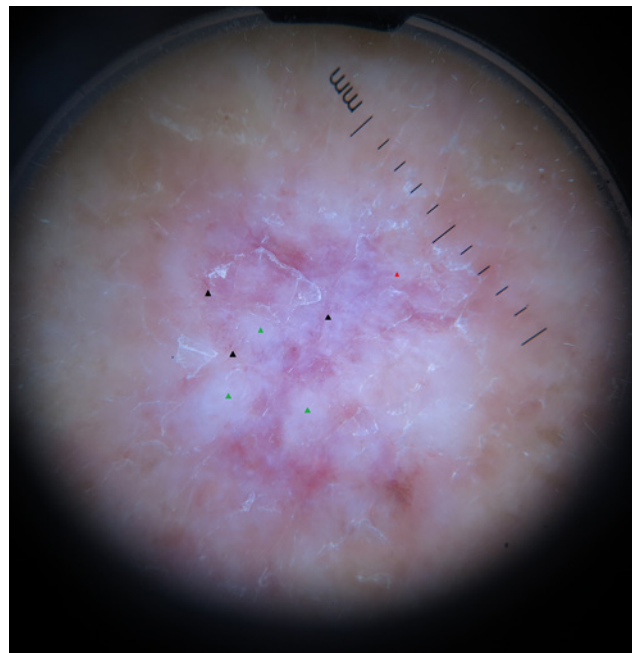


Figure 3. Lower lesion. Note the brilliant white blotches (green triangles), chrysalis (red triangle), and fine, ramified vessels over the whitish-pink background (black triangles). [Copyright: ©2018 Campos-Muñoz et al.]

and Spitz nevus, as well as of psoriasis and Bowen disease. Irregular linear vessels can be seen in different malignant cutaneous tumors, and when present it is advisable to take a biopsy. Red-milky areas are thought to represent neoangiogenesis and are a characteristic sign of hypomelanotic and amelanotic melanoma, but have also been described in nodular and sclerodermiform BCC [1]. Arboriform telangiectasias are very specific of BCC, but superficial lesions such as that of the present patient may only show very fine linear or serpiginous vessels with few ramifications.

Recently the importance of shiny white structures (blotches, long lines, rosettes, and chrysalis) in the diagnosis of nonpigmented BCC has been highlighted [2]. These signs are visible only under polarized light. The blotches are destructured areas and can be large or small and are brilliant white. The long lines may be thick or thin; they are never oriented orthogonally. The rosettes are groups of 4 white spots in a 4-leaf-clover arrangement. The chrysalis are short, shiny features oriented orthogonally with respect to one another and are present in BCC, melanoma, Spitz nevus, dermatofibromas, and benign melanocytic lesions. The lower lesion of the present patient showed brilliant white blotches, features seen more commonly in BCC (38%) than melanoma (9%). The simultaneous presence of blotches and long lines has been reported in some 48% of nonpigmented BCC lesions

[2], and for this reason is proposed as a diagnostic criterion (specificity 91%, sensitivity 30%).

In the present patient's upper lesion, a minimum amount of pigment appearing as brown spots suggested it to be melanocytic. The negative pigment network appeared as dark areas surrounded by clear, reticulate, and serpiginous lines. Histologically, it appeared to correspond to elongated fine crests. This finding is characteristic of melanoma and Spitz-Reed nevus.

Conclusion

In conclusion, this report highlights the need to assess the vasculature and brilliant white structures of nonpigmented skin lesions.

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