



International Dermoscopy Society

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Interested in submitting a quiz case for the IDS Newsletter ?

Just send an email to:
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Dear Readers,
in the current issue of the newsletter we will focus the attention on dermoscopic features of **seborrheic keratosis**. A dedicated section and the case of the newsletter will discuss about the many faces that these benign lesions can show, being sometimes not easy to differentiate from malignant keratinocytic tumors and melanoma.

I'd like also to give you updates about the decisions took by the **IDS board meeting** during the last assembly in New Orleans.

The assembly took place during the AAD congress in New Orleans on February 4, 2011.

Representatives of two societies operating in the field of non invasive diagnosis of skin tumors were invited to enter the board, namely Allan Halpern for the International Society of Digital Imaging of the Skin (ISDIS), and Giovanni Pellacani for the International Confocal Working Group (ICWG).

As already happened this year in New Orleans, the IDS meetings in the next years will take place in conjunction with the ISDIS meeting and ICWG meeting. These collaborative session will be scheduled once a year during the AAD congress and will mainly focus on a scientific agenda.

The assembly also decided to end the relationship with "Dermatology" as **official journal of the IDS**. The new journal will be Dermatology Practical and Conceptual. This is a free access, peer reviewed journal, first issued in October 2011. The collaboration with the journal will guarantee free access for 1 year to

Derm 101, a huge on line dermatologic resource, to all IDS members.

Finally, I'd like to highlight the ongoing **UDA project**. The aim of this project is to create a new, unified IDS-consensus algorithm composed of the dermoscopic features that are most discriminatory between nevi and melanoma. Additional aims will be to compare the current algorithms using a single evaluation session; to test the diagnostic value of new dermoscopic features that are not scored in the current algorithms and to test the difference between polarized and non-polarized dermoscopy regarding diagnostic accuracy by the different features.

We are very keen about this project and curious about the results, which could bring us to the definition of a new algorithm for diagnosing pigmented skin tumors. Broad participation of the IDS members is thus strongly encouraged.

Visit the IDS website to find more information

<http://dermoscopy-ids.org/images/stories/udaoutlineids.pdf>

Looking forward to seeing you soon at one of the next meetings

With all my best regards

Elvira Moscarella



SEBORRHEIC KERATOSIS

In the current issue of the IDS newsletter we focus on the many faces of seborrheic keratosis (SK) under dermoscopy.

SK are benign, very common, epithelial skin neoplasms that can appear on any body site except palms and soles. They usually begin as flat, sharply demarcated, brown macules and usually evolve within a solar lentigo. Later on, SK may become polypoidal with an uneven, papillated surface.

The three major types of SK, namely, acanthotic, reticulated and verrucous, display different dermoscopic features. These features are usually distinctive and the diagnosis of SK can be made easily, however in some cases, due to its many clinical and dermoscopic faces, even experienced dermatoscopists may have diagnostic problems. Uncommon variants include clonal SK (Borst-Jadassohn phenomenon), melanoacanthoma, and lichen planus like keratosis that can clinically and dermoscopically simulate other skin neoplasms, particularly melanoma. Irritated SK as well, can be of difficult differential diagnosis, because they may display an atypical vascular pattern.

Acanthotic type

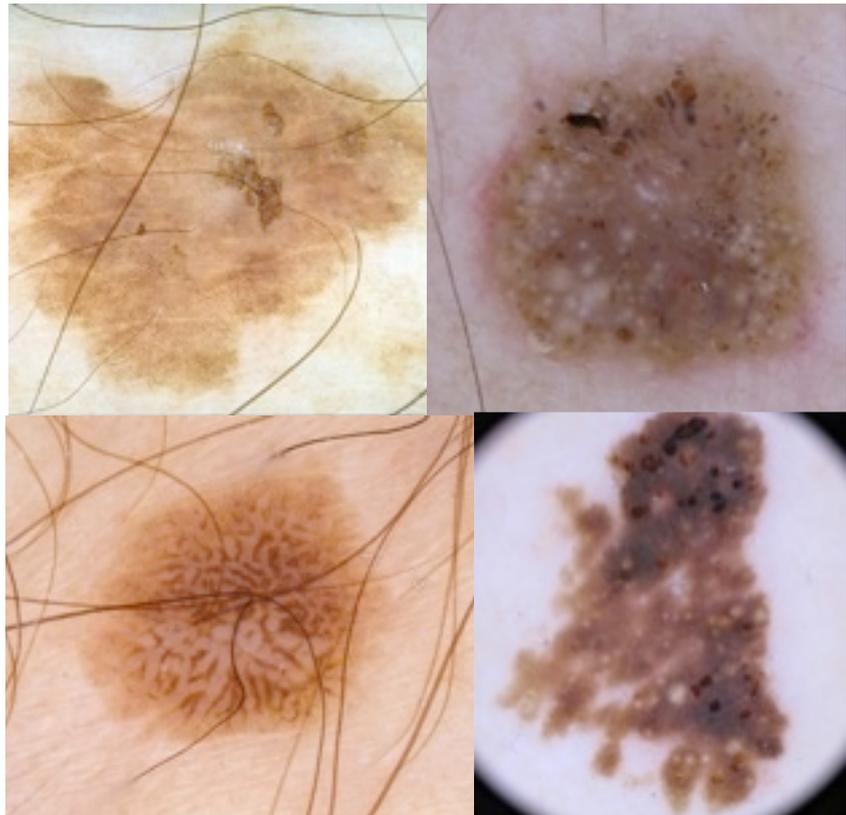


Fig1 SKs displaying fingerprinting (up left), numerous milia-like cysts (up right), cerebriform pattern (down left), multiple comedo-like openings (down right).

The dermoscopic hallmark of acanthotic SK are few to numerous **milia-like cysts** (whitish or yellowish structures that correspond to small intraepidermal, keratin-filled cysts) and several **comedo-like openings**. (keratin-filled invaginations of the epidermis) (fig1) The background coloration varies from an opaque light-brown to dark-brown or even black pigmentation.

Lesions are usually characterized by a **sharp demarcation**, sometimes with the so called **moth-eaten borders**, defined as concave areas at the edge of a lesion.

There is no pigment network, but small foci of **networklike structures** may be evident at the periphery of lesions. The lines of these structures are often hyperpigmented and may end abruptly at the periphery. The grids of these “networklike structures” are much larger than the one seen in a typical pigment network and the holes do not always correspond to the tips of the dermal papillae, but to keratin-filled structures (fissures, comedolike openings).

Sometimes a vascular pattern exhibiting **hairpin vessels** and dotted vessels can be appreciated. They correspond to long capillary

loops, commonly seen in keratinizing tumors, and are mainly found at the border or in the periphery of the lesions. In most of the cases, clusters of blood vessels are

grouped together and each of them has a whitish halo that gives them almost a “grapelike” appearance.

In lesions showing papillations upon clinical examination, exophytic papillary structures are observed dermoscopically.

In evolving acanthotic SK sometimes the global pattern resembles the surface of the brain, and the underlying dermoscopic structures are therefore called **gyri** and **sulci**. Histologically they correspond to rounded protrusions of acanthotic epidermis and papillary dermis (gyrus) surrounded on each side by furrows (sulci) filled with keratinous material. The yellowish to light-brownish lines between gyri are called **sulci or fissures** and are arranged reciprocal to the gyri, thus giving rise to the peculiar ‘brain-like’ appearance. (fig 1)

Sometimes the brain like appearance is not recognizable, and one can find the presence of the so called **Fat fingers**. They are thick digitate linear, curvilinear, branched, or oval/ circular dermoscopic structures, they represent the gyri of the cerebriform surfaces.



Fig 2. Clinical and dermoscopic features of a melanoacanthoma arising on the shoulder of a 60 year-old woman. The dark pigmentation does not allow to distinguish pathognomonic features of SK.

Reticulated type

The reticulated type of SK is characterized by a reticulated pattern. On the face it is combined with the site-specific pseudonetwork. This frequently causes diagnostic difficulties in the differentiation from melanoma in situ on severely sun-damaged skin (lentigo maligna).

In such cases the presence of a moth eaten border of the so called **jelly sign**, presence of pigment appearing as a smear, can be helpful for diagnosis.

A type of “network” that may be seen in a solar lentigo or an early seborrheic keratosis is “fingerprinting.” These are

networks that are light brown and delicate, and have a **fingerprint pattern**. (fig 1)

Verrucous type

The verrucous type of SK has an unspecific dermoscopic pattern. Because of the exaggerated orthohyperkeratosis, local features are not visible and therefore the dermoscopic examination only reveals whitish to yellowish horn masses.

Clonal SK

Clonal (nesting) seborrheic keratoses are characterized histopathologically by the presence of nests of cells that differ morphologically from their

neighbors within the background of a seborrheic keratosis.

Dermoscopic examination can reveal large areas of a bluish pigmentation composed of multiple, variously sized and irregularly distributed, blue-gray roundish structures, also aggregated to form short lines. The blue-gray structures are similar to the so-called blue-gray ovoid nests, which are a dermoscopic hallmark of pigmented basal cell carcinoma. Dermoscopy does not reach 100% diagnostic accuracy and clonal seborrheic keratosis may represent a dermoscopic pitfall, being difficult to differentiate from melanoma and basal cell carcinoma. Histopathologic examination should always be performed in cases in which dermoscopy reveals confounding features that do not allow an accurate diagnosis. (fig 3)

Melanoacanthoma

The melanoacanthoma variant presents a pronounced black pigmentation that is usually camouflaging the pathognomonic local features thus rendering these lesions difficult to differentiate from pigmented Spitz nevi and melanoma. (fig 2)

Lichen planus like keratosis

Lichenoid keratosis, or lichen planus-like keratosis (LPLK), has been proposed to represent a regressive epidermal lesion, either

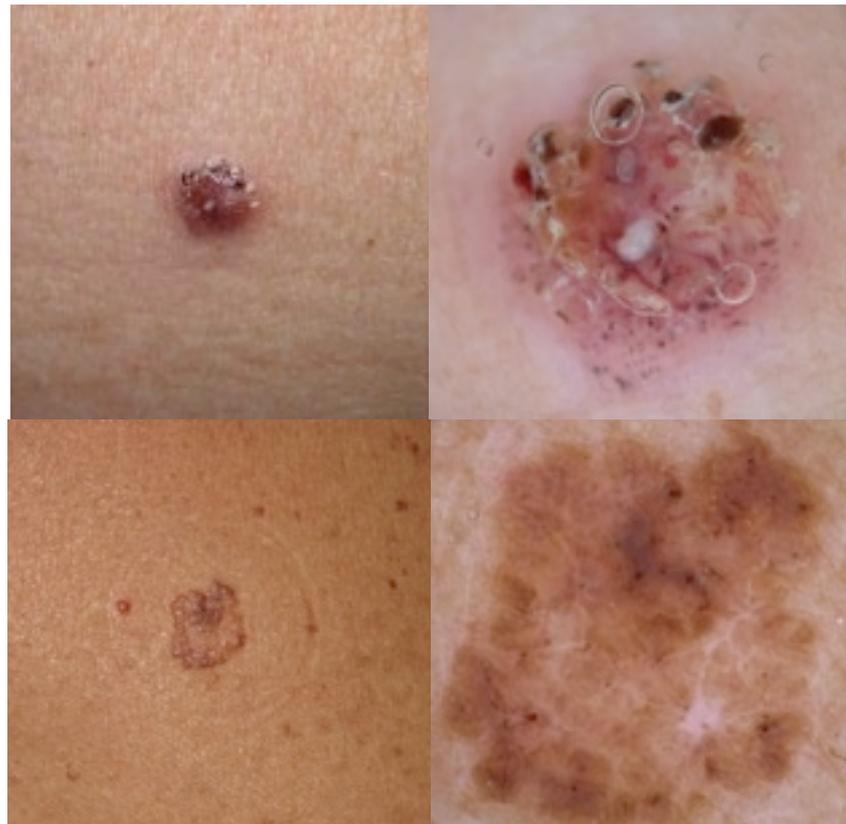


Fig 3. Irritated (up) and clonal (down) SK. Irritated SK displaying an atypical vascular pattern, within a background of scaling and crusts. Dermoscopy of clonal sk reveals the presence of some blue-gray structures that are similar to the so-called blue-gray ovoid nests, which are a dermoscopic hallmark of pigmented basal cell carcinoma

a solar lentigo or a seborrheic keratosis. At the end of the regressive process LPLKs usually show dermoscopically a diffused granular pattern, characterized by the presence of scattered grayish dots. Remnants of the preexisting lesion are detected in typical lesions. When only the latter granules and no additional clues are visible, an accurate differential diagnosis between LPLK and regressive melanoma is virtually impossible, and the lesion have to be excised for histologic diagnosis.

Irritated SK

Irritation can be responsible of the presence of variously sized and shaped scale-crusts, and atypical vasculature, thus masking the diagnostic features. (fig 3) Anti inflammatory treatment for a few weeks is sometimes sufficient to clarify the correct diagnosis.

CASE OF THE NEWSLETTER

FORUM CASE #59 BY PASTAR ZRINJKA

Title of request: What is your diagnosis?

Age: 43 years

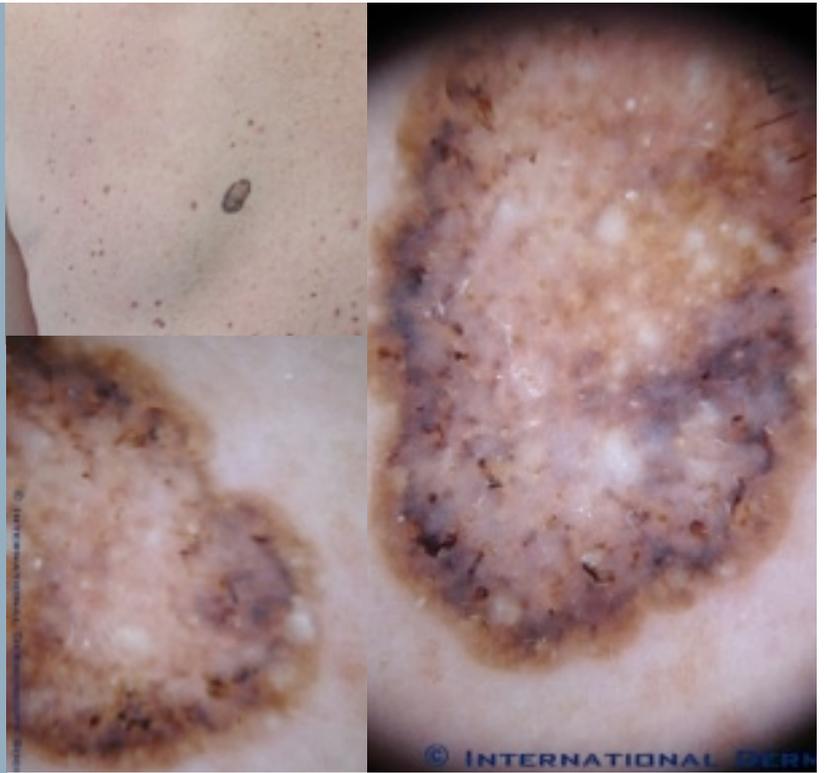
sex: m

skin type II

location: scapular region, left

clinical history: according to patient, the lesion is present since childhood and has not changed.

diagnosis: for discussion



Comments

Minas Stelios (5/8/2006 8:53:26 AM):

It is seborrheic keratosis.(multiple milia-like cysts,absent network,blue-gray globules,well demarcated border, comedo like openings and some fissures).

Giuseppe Argenziano (5/8/2006 7:46:35 PM):

very intriguing seb ker!! if the history is credible this might be an example of a congenital nevus becoming a SK. did you also notice in your practice that atypical mole syndrome in young adults is substituted by multiple SK in elderly??

Muir James (5/9/2006 2:10:09 PM):

Could it be an epidermal naevus (as opposed to a melanocytic one) that has undergone some regression?

That would explain the dermoscopic features outlined by Minas and the very long history. Also a congenital melanocytic naevus with a 'verrucous' surface and regression is possible.

The large areas of apparent regression and the blue grey areas all make me nervous. I don't believe the history he has given of no change.

I would not want this lesion on my back! For me I'd suggest getting it under a microscope.

Rodriguez Saa Sonia (5/9/2006 11:34:31 PM):

For me it is a seborrheic keratosis, but the history ???

Shah Syed N (5/11/2006 12:00:25 AM):

Very tricky. If there is a doubt, cut it out.

Pastar Zrinjka (5/12/2006 6:01:12 PM):

Thank you for your comments.

First of all, I first saw the patient when he came on excision in plastic surgeon office and I happened to be there. My clinical (not very well seen on the image 1. but the gut feeling was towards SK) and dermoscopic diagnosis was SK and I would have excised it as well. They were thinking of MM but they do not use dermoscope.:

Secondly, the patient history is as it is. However I also was not convinced that the lesion, at least, hasn't changed. Besides, he seemed very worried about it. And what would make him come for a check up? Moreover, concerning the long history, it has to be respected, so thank you for suggestions. Pathohistology is SK.

Muir James (5/15/2006 10:11:53 AM):

A useful lesson.

A very good dermatologist once told me when treating skin problems that I should 'take a thorough and complete history and then ignore it!'

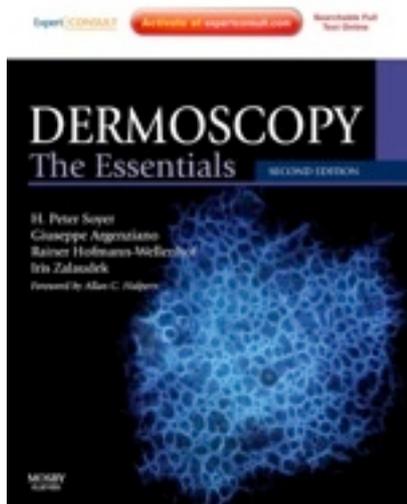
A lesion or a rash is what it is regardless of the history.

NEWS IN DERMOSCOPY

Dermoscopy, 2nd Edition

The Essentials: Expert Consult - Online and Print

By H. Peter Soyer, MD, FACD, Giuseppe Argenziano, MD, Rainer Hofmann-Wellenhof, MD and Iris Zalaudek, MD



Master of Science in Dermoscopy and Preventive Dermatoooncology (M.Sc.DermPrevOncol)



Continuing medical education and training programs help medical specialities dealing with skin cancer prevention, diagnosis and treatment to maintain their competence and to learn about new and developing areas in this field.

The **Master of Science in Dermoscopy and Preventive Dermato-oncology** is a 3 year postgraduate mostly distance learning course for physicians and nurses who wish to

gain expertise in the theoretical and practical diagnosis and management of skin tumors. Its qualification is granted with the **academic degree** of Master of Science in Dermoscopy and Preventive Dermato-oncology (**M.Sc. DermPrevOncol**).

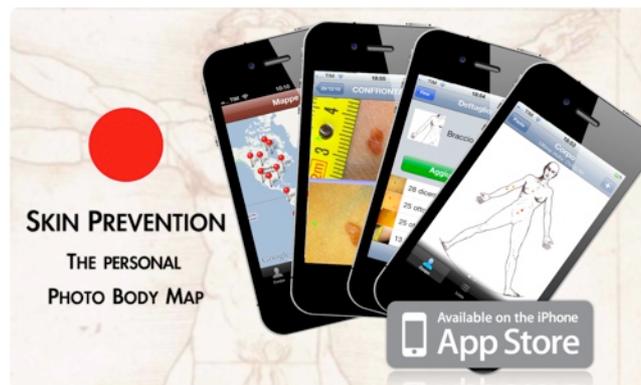
The master program guides through 3 different education levels. A highly interactive program will cover a broad range of topics at different levels ranging from melanoma and non-melanoma skin cancer epidemiology, primary and secondary prevention strategies, dermoscopic-pathologic correlations, basic and advanced dermoscopy, therapeutic options for skin tumors, aspects of rare skin tumors, update on recent research to future directions of non-invasive diagnostic techniques.

For further information please visit our homepage:

www.medunigraz.at/dermoscopy

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Skin Prevention – The personal Photo Body Map



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A new function will be available soon on the version 2.0 **offering a world wide geolocation** of a Directory of Dermatologists. **For free registration to the Directory visit: http://www.skinprevention.org/Skin_Prevention/registration.html**