WHAT IS THE DIAGNOSIS

Verrucous plaque on the cheek

Carolina Valdivieso,* Wladimir Preciado, Enrique Úraga,*****

* *Medical Resident of Dermatology Postgraduate course at Universidad Católica Santiago de Guayaquil*
** *Dermatologist at Dermatology Center Dr. Úraga*
*** *Director at Dermatology Center Dr. Úraga*

Correspondencia: carovaldiviesol@hotmail.com

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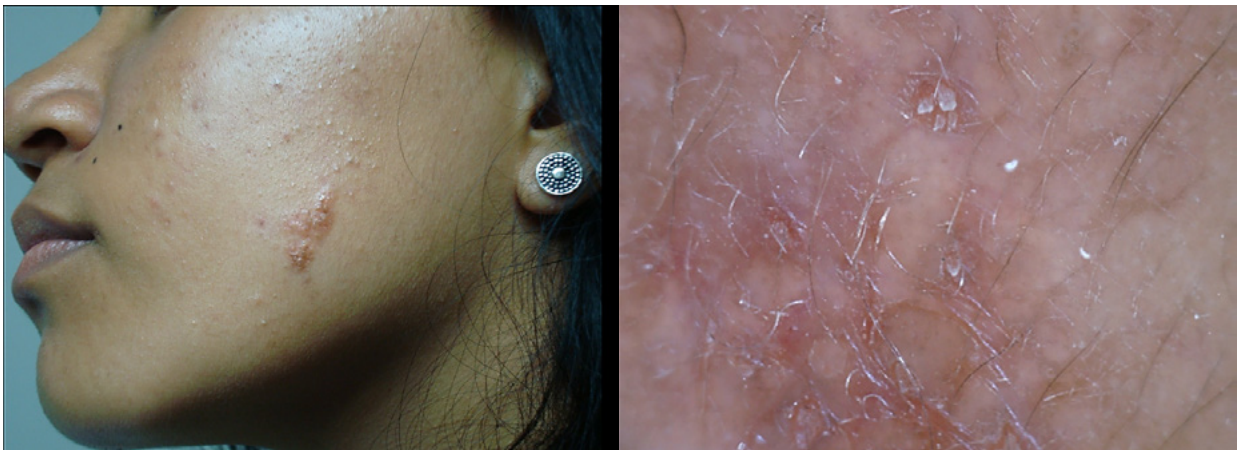
CLINICAL PICTURE

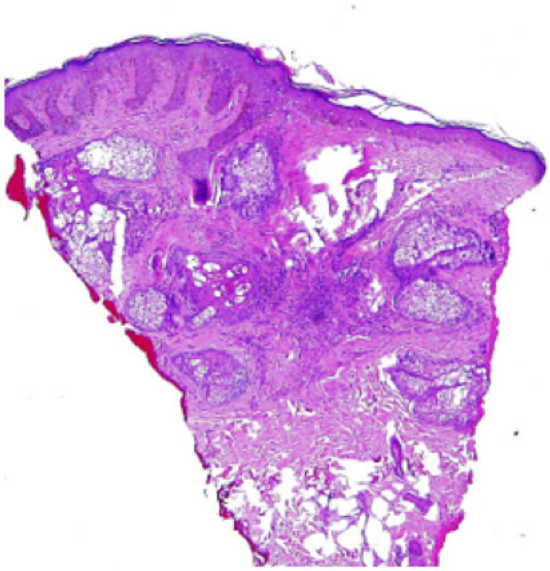
The case of a 13-year-old female patient with no relevant medical history is presented. The patient manifests a brownish-yellow elevated plaque in the lower third of the left cheek. This verrucous, polylobulated lesion, noted at birth, presents with slightly limited margins and elliptical configuration (Figure 1), measuring approximately 2.5 cm x 1.5 cm. Dermoscopy reveals exophytic papillary structures dispersed through a brownish surface in the form of plaques surrounded by whitish lines with a slight amount of desquamation in certain regions (Figure 2).

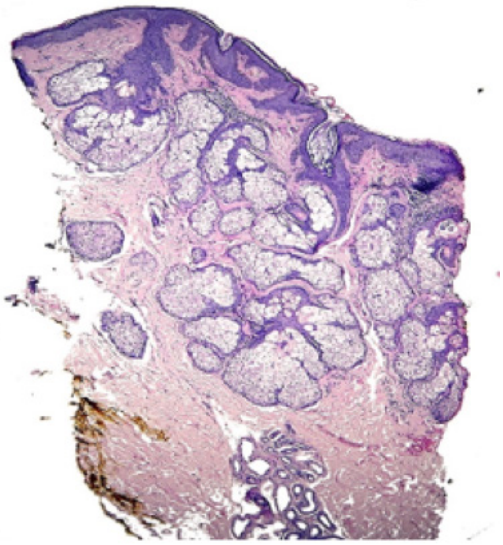
Due to the lack of specificity of the clinical presentation, several differential diagnoses are contemplated: xanthogranuloma, nevus sebaceous, linear epidermal nevus and warts.



WHAT IS THE DIAGNOSIS?

Histological confirmation through incisional biopsy (Figure 3) shows acanthosis, papillomatosis with discrete superficial perivascular inflammatory infiltrate, as well as hair follicles surrounded by numerous sebaceous glands, compatible with nevus sebaceous.





DISCUSSION

Organoid nevus, also known as nevus sebaceous of Jadassohn, was first described in 1895 as a complex hamartoma, involving the pilosebaceous follicle, epidermis and other adnexal structures.[1]

According to many authors, the incidence rate of this lesion is variable (little less than 0.2%).[2] It may be congenital or develop itself during early childhood.

Although causes for such lesion have yet to be determined, a malformation affecting both the ectoderm and the mesoderm is considered as a probable causality. Somatic mutation or lethal gene mosaicism has also been suggested as a cause. This lesion is most commonly identified on the scalp, face and neck.[3]

In 1965, Mehregan and Pinkus described three clinical stages:

1. Childhood stage: lesion manifests as a shiny and yellow hairless plaque; histopathology shows little to no underdeveloped sebaceous glands and hair follicles.
2. Puberty stage: lesion exhibits accelerated growth and becomes verrucous with lobular yellowish structures.
3. Final stage: characterized by the presence of nodules or tumors. Chronic lesions also present telangiectasias.[1-2]

The importance of the diagnosis lies on its association with secondary neoplasias: benign, which represents most cases (70%), such as trichoblastomas and syringadenomatosus papilliferus; or malignant, such as basal cell carcinoma, squamous cell carcinoma and featureless carcinomas.[4] Additionally, the risk of malignant transformation increases with age.[5-6]

Dermoscopy, included in the overall examination, is a valuable tool which shows several patterns: clustered yellowish or brown globules on a yellow background (1st stage); grayish papillary appearance and whitish-yellow lobular aspect (2nd stage); homogeneous yellowish aspect with or without vascularization (fine linear irregular or arborescent vessels), especially at the periphery (3rd stage - tumoral).[2]

Conversely, the most frequent histopathological findings are hyperkeratosis, immature hair follicles, sebaceous hyperplasia and verrucous epidermal hyperplasia, among others.[3]

To conclude, first-choice treatment is surgical excision.[2] However, other physicians choose to monitor the lesion, in case there is development of nodularities, ulcerations, cysts or papillomatous lesions which may suggest a malignant transformation.[5] Consequently, early sign recognition is crucial.

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