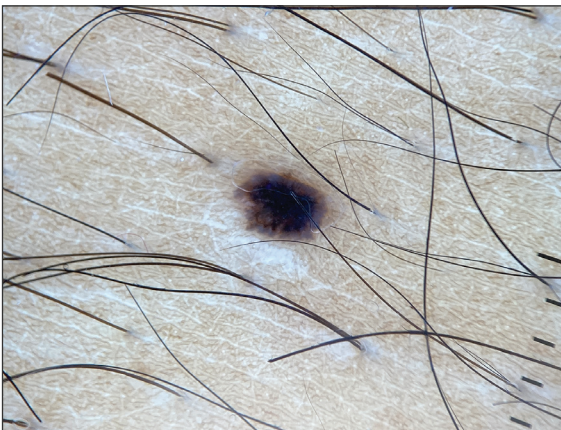


Dark-Brown Macule on the Periumbilical Skin

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A 33-year-old man with moderately to deeply pigmented skin presented to the dermatology department with a dark-brown macule in the periumbilical area of more than 1 year's duration. The patient was otherwise healthy and reported no personal or family history of atypical nevi, nonmelanoma skin cancer, or melanoma. Dermoscopy of the lesion showed a dark-brown macule less than 2 mm in diameter with a starburstlike pattern and a blue-hued border. A shave biopsy of the lesion was performed.

WHAT'S YOUR DIAGNOSIS?

- a. benign nevus
- b. dysplastic nevus
- c. melanoma
- d. seborrheic keratosis
- e. Spitz nevus

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THE DIAGNOSIS: Seborrheic Keratosis

Histopathology revealed epidermal hyperplasia and hyperkeratosis with no notation of atypical melanocytic activity (Figure). There were no Kamino bodies, junctional nesting, or cytologic atypia. Based on these features as well as the clinical and dermoscopic findings, a diagnosis of an inflamed seborrheic keratosis (SK) was made. No further treatment was required following the shave biopsy, and the patient was reassured regarding the benign nature of the lesion.

Seborrheic keratoses are benign epidermal growths that can manifest on any area of the skin except the palms and soles. They present clinically as tan, yellow, gray, brown, or black with a smooth, waxy, or verrucous surface. They range from 1 mm to several centimeters in diameter. Although SKs traditionally manifest more frequently in individuals with lighter skin tones, pigmented variants, such as dermatosis papulosa nigra, have been reported to occur more commonly and at younger ages in patients with skin of color.¹

Dermoscopy of SK in patients with skin of color can present diagnostic challenges, as these lesions may display atypical pigmented patterns that overlap with melanocytic lesions, including Spitz nevi, particularly when starburst-like or globular structures are present.² What sets inflamed SKs apart from other SKs is the lack of a heavily keratinized surface on both clinical and dermoscopic evaluation. Common histopathologic diagnostic criteria for Spitz nevi include Kamino bodies, uniform nuclear enlargement, and spindled or epithelioid nevus cells, which were not noted in our patient.³ Therefore, in presentations such as this, histopathology remains the gold standard for diagnosis.

The differential diagnosis in this case included benign nevus, dysplastic nevus, melanoma, and Spitz nevus. Benign nevi typically demonstrate uniform pigmentation and symmetric dermoscopic patterns. Dysplastic nevi may show architectural disorder and cytologic atypia but lack invasive features.³ Melanoma often exhibits asymmetry,

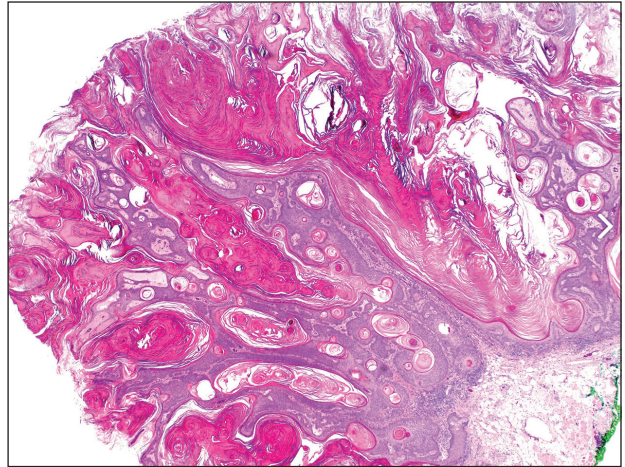


FIGURE. Histopathology of the periumbilical lesion showed epidermal hyperplasia and hyperkeratosis without melanocytic atypia (H&E, original magnification $\times 100$).

atypical network patterns, and irregular pigmentation.⁴ Spitz nevi characteristically demonstrate large epithelioid or spindle cells with Kamino bodies on histopathology, which were absent in our patient.

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