

## THE CLINICAL PICTURE

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# The Clinical Picture

## An ulcerated plaque on the hand



FIGURE 1.



FIGURE 2.

**A** 73-YEAR-OLD FARMER has a lesion on the dorsum of his right hand that bleeds intermittently. It began 2 years ago as a small itchy papule. It later ulcerated and has gradually increased in size over the past 2 years.

On examination, the lesion is a nontender, ulcerated plaque, 4 cm by 5 cm, with hard and raised edges (FIGURE 1 and FIGURE 2) and with evidence of chronic photodamage. No local adenopathy is noted.

**Q:** Which is the most likely diagnosis?

- Blastomycosis
- Keratoacanthoma
- Basal cell carcinoma
- Squamous cell carcinoma
- Extramammary Paget disease

**A:** **Squamous cell carcinoma** is the most likely diagnosis. The lesions may take the form of a patch, plaque, or nodule, sometimes with

scaling or an ulcerated center. The borders often are irregular, fleshy, and bleed easily.

**Blastomycosis** is a rare fungal infection caused by inhaling the spores of the fungus *Blastomyces dermatitidis*. Skin features begin as papules, pustules, or subcutaneous nodules. Over a period of months, lesions heal to form raised wart-like scars, which are often irreversible.

**Keratoacanthoma** is a benign nonmelanomatous cancer that grows rapidly and remits spontaneously. This diagnosis is unlikely in our patient, whose lesion evolved over 2 years.

**Basal cell carcinoma** has a waxy, translucent, or pearly appearance, without a keratotic component. Telangiectasias are common. Unlike squamous cell carcinomas, the edges of basal cell lesions are clear rather than fleshy.

**Extramammary Paget disease** usually manifests as intense pruritus in affected areas, which appear as chronic intertrigo or nonre-

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## ULCERATED PLAQUE

solving eczema. The dorsum of the hand is a very rare location for this disease. Given our patient's presentation, extrammary Paget disease is an unlikely diagnosis.

### ■ CHRONIC SUN EXPOSURE IS A KEY RISK FACTOR

Our patient has worked outdoors for many years, and chronic sun exposure is a key risk factor for squamous cell carcinoma.<sup>1</sup>

Squamous cell carcinoma is a nonmelanomatous skin cancer arising from the more superficial layers of keratinocytes. Unlike basal cell carcinoma, it can metastasize,<sup>2</sup> so the diagnosis must be made as soon as possible.

The key to diagnosis is a high degree of suspicion. Patients usually present with chronic sun-damaged skin with lesions as actinic keratoses or keratin horns. Squamous cell carcinoma appears as a thick, adherent scale that does not heal and may intermittently bleed. Because it spreads into the dermis, it can appear like an ulcer, with hard, raised edges, as in our patient.

### ■ TREATMENT AND PREVENTION

The standard effective treatment is complete surgical excision.<sup>1</sup> Nonsurgical treatments include curettage plus cautery, cryosurgery, radiotherapy, photodynamic therapy, and imiquimod (Aldara) 5% cream. Minimizing sun exposure and regular checkups are important preventive measures.

Our patient underwent total surgical excision of the lesion. Due to the size of the lesion, a skin graft was required and was obtained from the abdomen. No relapse was observed after 1 year of follow-up.

### ■ REFERENCES

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