

## Mixed Eyelid Lesion: Seborrheic Keratosis on Basal Cell Carcinoma with Heterogeneous Pattern

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### ABSTRACT

Mixed, contact or coexisting skin lesions attract a lot of attention from the clinician and have been the subject of multiple references in the literature. Sometimes these are morphological curiosities without therapeutic or prognostic repercussions. However, there are cases in which its diagnosis involves a different way of proceeding after the diagnosis. We present a case of basal cell carcinoma hidden under seborrheic keratosis. The action of the dermatologists avoided unnecessary surgeries in a delicate location. The images speak for themselves.

### INTRODUCTION

Mixed, contact or coexisting skin lesions attract a lot of attention from the clinician and have been the subject of multiple references in the literature. Sometimes these are morphological curiosities without therapeutic or prognostic repercussions. However, there are cases in which its diagnosis involves a different way of proceeding after the diagnosis. We present a case of basal cell carcinoma hidden under seborrheic keratosis. While seborrheic keratosis is a benign epithelial lesion whose treatment responds mainly to aesthetic purposes, to symptoms related to its irritation or trauma, or to its differential diagnosis with different keratotic neoplastic lesions, basal cell carcinoma is a malignant neoplasm (the most frequent) which, depending on its location, time of evolution and phenotype, can lead to therapeutic difficulties and, in rare advanced cases, significant health problems. The action of the dermatologists avoided unnecessary surgeries in a delicate location. The images speak for themselves. Both lesions are frequent and are rarely described as concomitant. This is a good opportunity to emphasize this situation, probably much more frequent than that reflected in the literature.

### CASE REPORT

A 69-year-old male patient, with no relevant pathological history, who attended the dermatologist due to the presence, at the level of the lower left eyelid, of a pigmented and keratotic lesion, non-excreting, of 0.9 cm. of maximum dimension that has grown and produced discomfort in recent months. With the clinical judgment of seborrheic keratosis, surgical excision of the lesion was performed. The section showed that, in depth, 0.1 cm from the epidermal surface, there was a nodular and lobulated lesion with a pseudocystic appearance of 0.4 cm in maximum dimensions.

The histological study showed the presence on the surface of an epithelial hyperplasia without atypia. Simple and reticular acanthosis and basaloid phenotype in cells were present and both corneal cysts and pseudocysts were observed. Underlying this lesion,

there were multiple intradermal nodules of geographic morphology, made up of basaloid cells with moderate atypia, which formed peripheral palisades, some of them surrounded by retraction artifact. A central neoplastic nest made up of basaloid cells with focal mucinous change at the peripheral level, surrounding a partially hyalinized central collagen-fibrinous matrix, in the center of which there were few basaloid neoplastic nests, was particularly noteworthy (Figure 1-6). With these findings, the diagnosis of seborrheic keratosis with an acanthosis pattern was made on basal cell carcinoma with a macro and micronodular pattern with a focus of central intracystic hyalinization. The resection margins were free of neoplasia. No recurrences have been recorded after one year of follow-up. We have no clinical images.



Figure 1: Macro-micro picture of the lesion.

## DISCUSSION

We do not intend to repeat the history of basal cell carcinoma, well known in specialized forums and well described in specialized articles [1,2]. Being the most frequent malignant neoplasm and having recognized multiple morphological patterns, we present a peculiar case since the presence of a

concomitant superficial seborrheic keratosis avoided suspecting the presence of the underlying carcinoma. This is yet another example of contact or mixed injuries.

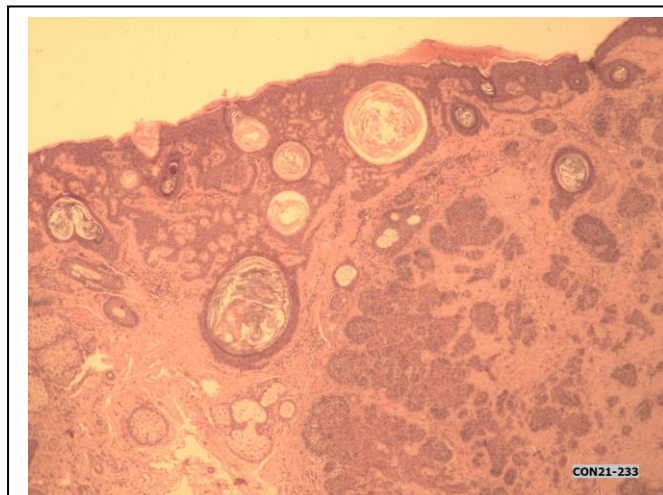


Figure 2: Seborrheic keratosis over basal cell carcinoma. The relationship of both lesions is observed. The image shows the presence of a large cystic-appearing neoplastic nodule surrounded by geographic basaloid nests, underlying the seborrheic keratosis. HE 40x.

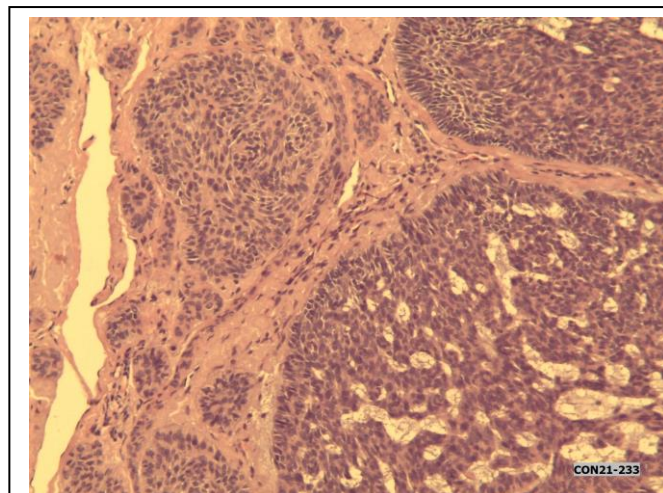


Figure 3: Seborrheic keratosis over basal cell carcinoma. Detail of the periphery of the larger neoplastic nest, with mucinous differentiation. HE 100x.

The eyelid location of a seborrheic keratosis is usually approached by means of tangential resection of the lesion, although the dermatological team opted to perform a relatively wide excision as they found infrequent characteristics when proceeding with surgery. This prevented the invasion of the surgical margins and, in turn, a second intervention on such a delicate area. From the histological point of view, two facts stand out. The first is the phenotypic dichotomy within the same



basal cell carcinoma since the peripheral geographic nests did not show retraction artifact or mucinous changes, while the main nest, in addition to presenting it, delimited a rather characteristic hyalinization and fibrosis zone.

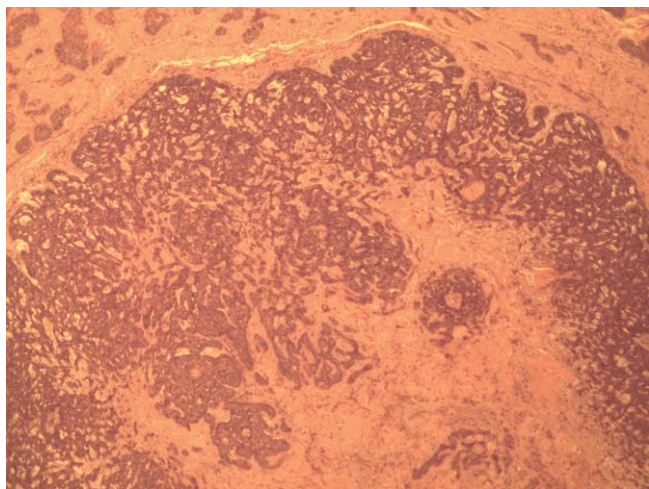


Figure 4: Seborrheic keratosis over basal cell carcinoma. Detail of the largest nodule in basal cell carcinoma. The characteristic stromal hyalinization is seen in the center. HE 40x.

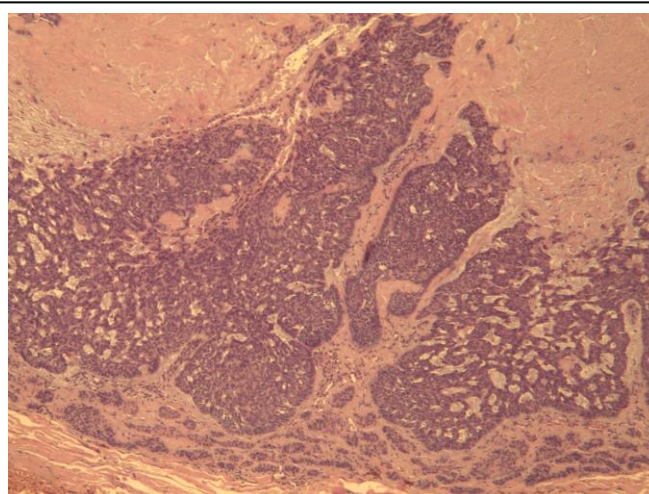


Figure 5: Seborrheic keratosis over basal cell carcinoma. The image shows the periphery of the larger nest and the presence of peripheral solid basaloid nests of smaller size. HE 100x

Images are highly demonstrative.

Then the question that various authors have asked arises. Are these two different lesions or does the carcinoma arise from a previous seborrheic keratosis? We could also open the field of hypotheses to the fact that seborrheic keratosis is the consequence of epidermal induction by the underlying neoplasia. Immunohistochemical studies have been included in the discussion [3-7].

Our patient was aware of his injury and came to the consultation due to the increase in size and discomfort, which reinforces the hypothesis that seborrheic keratosis already existed prior to the growth of the basal cell carcinoma, a case very similar to the one written by Shibao and cols [8].

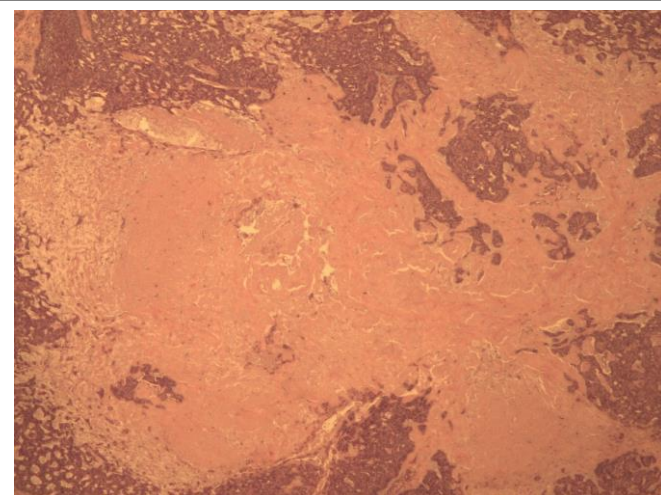


Figure 6: Seborrheic keratosis over basal cell carcinoma. Detail of the largest nodule in basal cell carcinoma. The characteristic stromal hyalinization is seen in the center. HE 200x.

## LESSONS TO TAKE HOME

1. Do not assume that the identification of one type of injury prevents the association of a second type of injury.
2. The macroscopic image of different dermatological lesions is nonspecific.
3. The lesion of a higher histological grade is therefore located below the lower grade and therefore may go unnoticed after incomplete resection by slicing.

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