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Case Report

Compound Nevus Mimicking a Seborrheic Keratosis: A Keratotic Melanocytic Nevus without Any Dermoscopic Criteria for a Melanocytic Lesion

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Abstract

Observations: We report an exceptional case of a compound nevus in which none of the criteria described for a melanocytic lesion was observed on dermoscopy. The lesion was a keratotic compound nevus and this case demonstrated that diagnosis of a keratotic melanocytic nevus might be difficult both clinically and dermoscopically.

Introduction

Compound nevus is a common melanocytic lesion which demonstrates both junctional nests and intradermal melanocytes. It is generally seen as a papule or plaque with a smooth surface, uniform border and pigmentation. It exhibits a pigment network and brown globules distributed regularly on dermoscopy. Rarely, milia-like cysts and comedo-like openings can also be observed, although these two are the characteristic dermoscopic features of seborrheic keratosis [1].

We report a case of a compound nevus with dermoscopic features difficult to differentiate from seborrheic keratosis.

Case Report

The lesion was a light-brown pigmented plaque which was 14 x 4 mm in diameter on the neck of a 16-year-old female. On dermoscopy, multiple comedo-like openings distributed extensively throughout the lesion and some milia-like cysts were seen (**Figure 1a**). Careful examination revealed none of the criteria for a melanocytic lesion (pigment network, aggregated globules, streaks or homogeneous blue pigmentation). Considering the young age of the patient, the lesion was excised to explore melanocytic/non-melanocytic nature of the lesion with the preoperative diagnosis of a seborrheic keratosis. Histopathologically, epidermal hyperplasia and hyperkeratosis, multiple keratotic plugs between the digitiform papillations formed by papillomatosis, and horn pseudocysts were seen together with nevus cell nests both in the dermal/epidermal junction and the dermis. Junctional nests were mostly right beneath the keratotic plugs and horn pseudocysts (**Figure 1b**). The diagnosis was a keratotic compound nevus.

Discussion

The two-step algorithm should be followed in the dermoscopic classification of pigmented skin lesions. In the first step which differentiates a melanocytic versus non-melanocytic lesion, pigment network, aggregated globules, streaks or homogeneous blue pigmentation should be searched. If

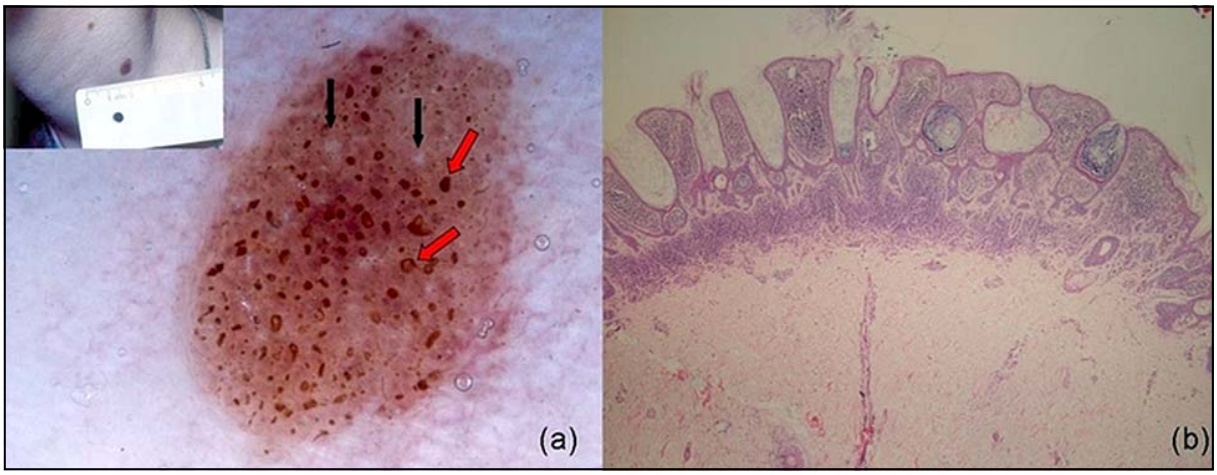

Figure 1. (a) Extensively distributed comedo-like openings (red arrows) and a few milia-like cysts (black arrows) on dermoscopy. Inset: Light-brown pigmented plaque on the neck. **(b)** Low power view of the lesion characterized by papillomatosis, hyperkeratosis, horn pseudocysts and nevus cells (HE x 40).

these criteria characteristic for a melanocytic lesion are absent, and the dermoscopic features for a nonmelanocytic one are observed, the lesion should be diagnosed as a nonmelanocytic pigmented lesion [2].

The present case showed none of the criteria for a melanocytic lesion. Histopathologically the extensive keratotic plugs and horn pseudocysts which were seen as pseudofollicular openings and milia-like cysts respectively on dermoscopy may have obscured the nevus cell nests which were coincidentally mostly right underneath them, thus leading to a diagnosis of a seborrheic keratosis instead of a compound nevus.

Melanocytic nevi showing marked epidermal hyperplasia and hyperkeratosis seen frequently together with horn pseudocysts have been described as keratotic melanocytic nevi [3, 4]. Histologically they are reported to consist 6% of melanocytic nevi. They are commonly biopsied since many are clinically considered atypical besides having other clinical diagnoses of nevi not otherwise specified, seborrheic keratosis, acrochordon and basal cell carcinoma [4].

The present case is a keratotic compound nevus showing prominent epidermal features. This case demonstrates that a keratotic melanocytic nevus may be misdiagnosed as a seborrheic keratosis both clinically and dermoscopically.

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