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# **Barnacles, Old Age Marks, or Just Plain Seborrheic Keratoses**

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Growing older may mean more wrinkles and creaking joints, but why does it also entail an accumulation of barnacles. These brown, somewhat friable, often warty lesions are more common on senior citizens but are not necessarily limited to the chronologically challenged. Seborrheic keratoses (SKs) can be easily recognized (fig 1), but the itching and the occasional scratch-induced dermatitis make them more than a cosmetic nuisance. (fig 2)

SKs can go by a variety of names, ranging from basal cell papillomas, senile warts, and senile keratoses to seborrheic verrucae and verrucous senilis. The various terms provide no more information on their natural history or the etiology of these benign lesions, other than that age is somehow associated. (1)

## **Etiology**

The etiology of the SK is elusive, despite its long time recognition. There is some evidence that the human papillomavirus (HPV) plays a role in its development. (2, 3), but Koch's postulates have yet to be fulfilled. Through the use of such current laboratory tools as in situ hybridizations (ISH), polymerase chain reactions (PCR) Southern blot hybridizations, and sequencing of viral DNA of PCR-amplified fragments, HPV has been implicated, particularly types 6 and 18. Unfortunately, we still await final confirmation or disassociation.

The poxvirus associated with molluscum contagiosum and even a herpesvirus have also been found in SK-like lesions(4). To complicate the issue further, actinic keratoses are not alone in being sun-induced, for it seems that patients have more SKs, if they have had many and extensive sunburns. (5)

### **Clinical Findings**

The traditional SK can vary anywhere in size from a few mm to a few cm. It rarely appears in younger patients, has no gender preference, and is not found on mucous membranes or the palms and soles. Sometimes, it is flat enough that only the brownish discoloration and possible scaling give its presence away. Other times, it is unevenly elevated and irregularly pigmented to provide the experienced clinician with concern about a possible malignancy, such as melanoma,(6) basal cell carcinoma, or squamous cell carcinoma.(7) Fortunately, the clinical picture of the SK is characteristic enough that a biopsy is infrequently needed.

### **Established Variations**

#### **Dermatosis papulosa nigra**

First described by Castelanni in 1925, dermatosis papulosa nigra (DPN) (fig 2) is found in black patients, predominantly women past thirty, who have their roots in the Caribbean or Central America. A DPN is a small, darkly-colored, elevated lesion that can be clustered, most often on the face. Although these nuisances were once considered to be hereditary in origin, the histopathology suggests that a DPN is little different from an ordinary SK. (8)

#### **Stucco keratosis**

The stucco keratosis (fig 3) is usually found on the legs of older men, often in association with xerosis. It is white to gray with some scaling, giving the appearance that it was glued onto the skin as an after thought. When removed, there is little to no bleeding. (9)

#### **Sign of Leser-Trélat**

The sign of Leser-Trélat has created another enigma, since it inception a century ago. Does the sudden onset of many SKs indicate an underlying malignancy? Again, carcinomas occur in older patients, and older patients have SKs. While this finding may

be considered a paraneoplastic sign, the correlation has come under attack.(10) A similar situation occurred a few decades ago with herpes zoster, when it is diagnosed in older patients who also have malignancies.

### **Conclusions**

SKs and their variations are not destructive, so the question arises about intervening. They sometimes disappear of their own accord and treatment has little risk, whether the approach is surgical (snipping, curettage, electrodesiccation, cryosurgery, etc. or chemical (salicylic acid, trichloroacetic acid, aquaglycolic acid, etc.).

When do we intervene? 1) When the itching and secondary dermatitis become problems, the lesion(s) should be eliminated. 2) When the patient or special other has concerns about cancer and reassurance does not eliminate the doubt, the SK(s) should be removed. 3) When this benign lesion catches on clothing or jewelry, intervention is in order. Lastly, 4) when the peers of the patient or the grandchildren continue to fret about the barnacles, it is time to do something.

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Fig. 1 Seborrheic keratoses

Fig. 2 Seborrheic keratoses with irritant dermatitis

Fig. 3 Dermatitis papulosa nigra

Fig. 4 Stucco keratoses (note choice of two pictures)