Artigo de Dermatoscopia

DOENÇA DE BOWEN PIGMENTADA MIMETIZANDO MELANOMA - CLÍNICA DE DERMATOSCOPICAMENTE

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RESUMO – Uma variedade de lesões cutâneas pode simular melanoma, tais como nevos melanocíticos, lentigos, ceratose seborreica, nevo azul, carcinoma basocelular pigmentado e dermatofibromas. Relata-se um caso clínico raro de uma paciente do sexo feminino que apresentou lesão em coxa esquerda clínica e dermatoscopicamente compatível com melanoma. A paciente foi submetida à exérese da lesão e o histopatológico diagnosticou doença de Bowen pigmentada. O objetivo é alertar que a doença de Bowen pigmentada, uma forma rara de carcinoma espinocelular in situ, também deve ser lembrada como diagnóstico diferencial de melanoma maligno.

PALAVRAS-CHAVE – Dermoscopia; Doença de Bowen; Melanoma; Neoplasias da pele.

PIGMENTED BOWEN'S DISEASE MIMICKING MELANOMA CLINICALLY AND DERMOSCOPICALLY

ABSTRACT – *A variety of cutaneous lesions can mimic melanoma, such as melanocytic nevi, lentigines, seborrheic keratosis, blue nevi, pigmented basal cell carcinomas and dermatofibromas. This report describes a rare clinical case of a female patient who presented a lesion on the left thigh, which was clinically and dermoscopically compatible with melanoma. The patient underwent excision of the lesion, and histopathology confirmed a diagnosis of pigmented Bowen's disease. The purpose of this report is to draw attention to the fact that pigmented Bowen's disease, a rare form of squamous cell carcinoma in situ, should also be considered as a differential diagnosis of malignant melanoma.*

KEY-WORDS – *Bowen's disease; Dermoscopy; Melanoma; Skin Neoplasms.*

Conflitos de interesse: Os autores declaram não possuir conflitos de interesse.
No conflicts of interest.
Suporte financeiro: O presente trabalho não foi suportado por nenhum subsídio ou bolsa.
No sponsorship or scholarship granted.
Direito à privacidade e consentimento escrito / ***Privacy policy and informed consent***: Os autores declaram que pediram consentimento ao doente para usar as imagens no artigo. *The authors declare that the patient gave written informed consent for the use of its photos in this article.*

Recebido/*Received* - Dezembro/*December* 2013; Aceite/*Accepted* - Janeiro/*January* 2014

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CASE REPORT

A 57 year old woman came to our clinic with a one--year history of a lesion on the left thigh. Dermatological examination confirmed hyperchromic macule, the upper half of which presented dark brown pigmentation and the lower half was light-colored, and measured 1.0x0.5cm in diameter, located on the inner left thigh (Fig. 1). Non-polarized light, contact dermoscopy (Delta 20) indicated brownish globules with branched streaks and pseudopods at the periphery at the most pigmented region of the lesion (Fig. 2). Histopathologic analysis performed after excision revealed epidermal acanthosis with hyperkeratosis, nuclear keratinocyte atypia extending from the basal layer to the surface, with mitoses, dyskeratosis and foci of melanin hyperpigmentation. Together these histopathology findings confirmed the diagnosis of Bowen's disease (Fig. 3).

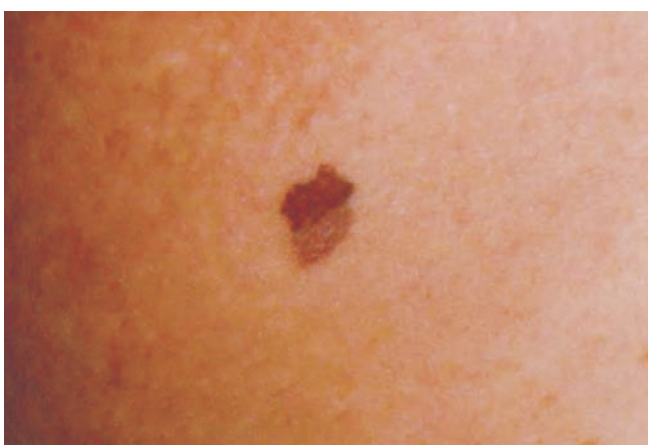

Fig. 1 - Lesion on the inner thigh mimicking melanoma.

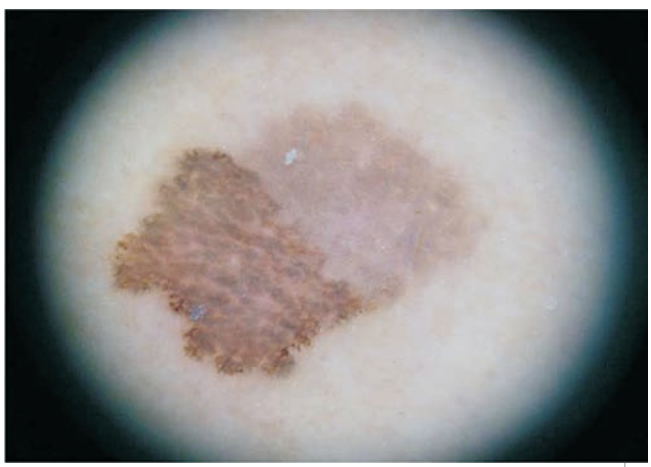

Fig. 2 - Dermoscopy showing branched streaks and pseudopodia. Brownish globules in the most pigmented area of the lesion can also be seen.

DISCUSSION

Bowen's disease is a superficial variant of squamous cell carcinoma that may develop into invasive carcinoma in 3-5% of all cases[2]. Its most common clinical presentation is a erythematous scaly or crusty plaque that appears, usually in sun-exposed areas[2]. The pigmented form, as in this case report, represents less than 2% of all cases of Bowen's disease[3]. It is clinically presented as a well-defined, hyperpigmented plaque, with a smooth, velvety or hyperkeratotic surface[4]. Desquamation and erosions may also be present. Development is slow and progressive, and is generally asymptomatic; with the possible occurrence of local pain, irritation, itching and bleeding[5]. It is commonly located in intertriginous areas[3].

When conducting dermoscopical examination on pigmented Bowen's disease, it is possible to detect more than one color, globules, branching strands and pseudopodia, all of which were encountered in the reported case. It is also possible to find brown or grayish spots, hypopigmentation with structures and vessels in a linear, tree-like or spiral arrangement[6].

In the present case, the use of non-polarized contact dermoscopy may not have enabled the visualization of vascular structures.

An important differential diagnosis is malignant melanoma, which may present the same clinical and dermoscopic features[4]. Definitive diagnosis is carried out by histopathology. Epidermal acanthosis with hyperkeratosis and foci of parakeratosis, keratinocyte atypia with a

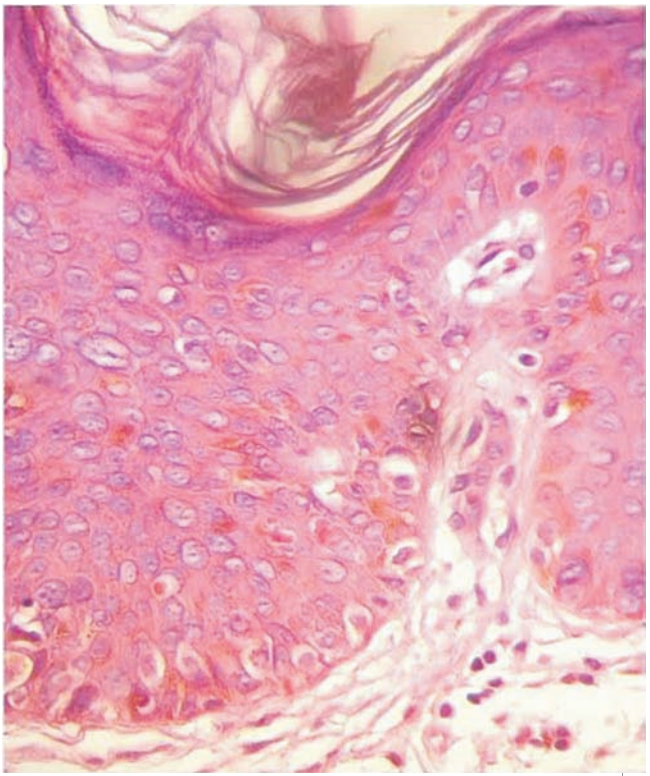

Fig. 3 - Atypical keratinocytes occupying the entire thickness of the epidermis with foci of melanin pigmentation.

loss of nuclear polarity are all presented in pigmented Bowen's disease. Mitoses, dyskeratosis and increasing melanin in the basal layer are also encountered[3], as confirmed by the histopathological analysis of the presented case.

Several therapeutic options are available for Bowen's disease. Surgical excision is still considered gold standard, however, recent studies have demonstrated the efficacy of other treatments such as cryotherapy, curettage and electrocoagulation, radiotherapy, 5-fluorouracil, imiquimod, photodynamic therapy and laser[2].

Unlike Bowen's disease, melanoma is a type of cancer with highly invasive and metastatic potential. Thus, the best therapeutic option is surgical excision, reserving other options for cases where performing surgery is not possible.

In conclusion, therefore, despite the relative infrequency of pigmented Bowen's disease, special attention should be paid to this pathology due to its capacity of mimicking malignant melanoma, as described in the present case report. It is important to conduct a histopathological study in order to confirm diagnosis and define the most appropriate treatment.

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