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# A Slow Growing Verrucous Plaque on the Scalp

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# A Slow Growing Verrucous Plaque on the Scalp

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## History

- A 73 year-old Caucasian male with a history of multiple non-melanoma skin cancers presented to dermatology for evaluation of a growth on the left scalp.
- He endorsed that the lesion had been present for many years but was slowly growing larger and thicker.
- More recently, the lesion had bled spontaneously and had become intermittently painful.
- The lesion had been evaluated several times over a span of 3 years and was previously thought to most likely represent a verrucous seborrheic keratosis.
- The patient was otherwise in a good state of health and had no known history of immunosuppression.

## Examination

- On the left parietal scalp there was a pink-brown verrucous plaque with filiform projections and focal hemorrhagic crust (Fig 1). The lesion measured 5.2 cm x 3.8 cm.

## Clinical Photo



Fig 1. Verrucous plaque with hemorrhagic crusting on the scalp

## Histopathology

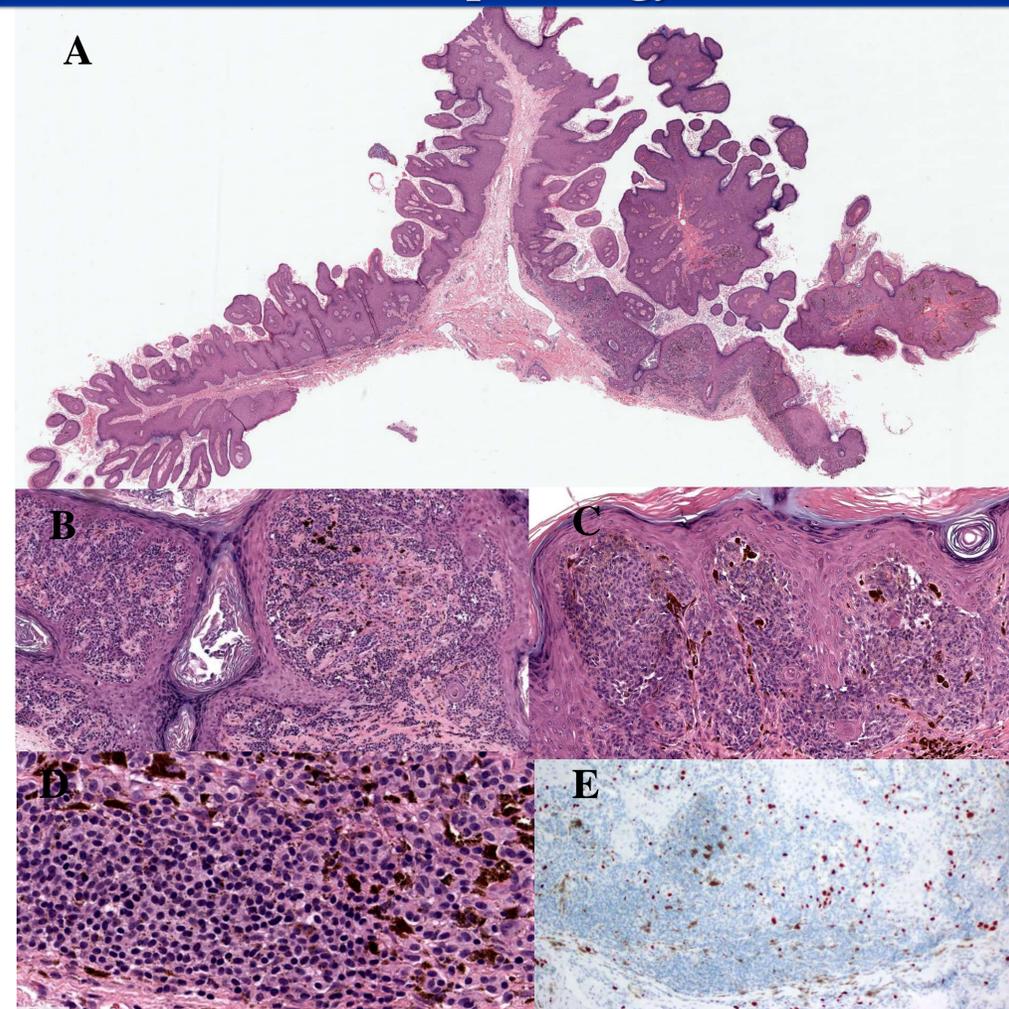


Fig 2. A. Scanning view demonstrating marked epidermal hyperplasia and papillomatosis overlying a broad melanocytic proliferation. B, C. Dendritic melanocytes with prominent nucleoli are seen proliferating at the dermo-epidermal junction in a near-confluent fashion. D. Sheets of small-to-medium, relatively uniform melanocytes are seen in the upper dermis. E. P16 staining reveals loss of reactivity in the melanocytes, which are organized in sheets.

## Course and Therapy

- Saucerization biopsy of the most inferior, exophytic portion of the lesion was performed for histopathologic analysis.
- Histopathology revealed a broad, atypical melanocytic proliferation within a larger verrucous keratosis with features consistent with a ‘verrucous pseudonevoid melanoma of the scalp’ (Fig 2.). The Breslow depth was measured at 1mm.
- The patient was treated with a wide local excision with 1 cm margins. The re-excision specimen showed focal residual melanoma in-situ and clear margins. A sentinel lymph node biopsy was performed for staging and was found to be negative for metastatic disease.

## Discussion

- Nevoid melanoma is a rare entity which presents diagnostic difficulty on both clinical and histopathological grounds.
- On physical examination this tumor can be mistaken clinically for a verruca, benign melanocytic or epidermal nevus, or seborrheic keratosis.
- There are two major architectural variants: verrucous subtype and a dome-shaped variant (resembles a Meissner or Spitz nevus).
- Verrucous-subtype (as seen in our case) has been reported to have the following features which may distinguish it from a papillomatous nevus:
  - Broad, exophytic growth pattern with a verrucous epidermal hyperplasia
  - Continuous proliferation of melanocytes along the dermal-epidermal junction
  - Confluent sheets of uniform, monomorphic without evidence of true maturation.
  - Occasional dermal mitoses
- Mortality is thought to be consistent with that of traditional melanomas of the same Breslow depth.
- Nevoid melanomas are commonly more advanced at the time of diagnosis given propensity for initial clinical and/or histologic misdiagnosis.
- Heightened awareness of this entity is critical to better ensure earlier diagnosis.

## References

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