Quiz

Asymptomatic nodule on the scalp

A 60-year-old male presented to our outpatient department with an asymptomatic raised lesion on the left side of the scalp for 2 years. The lesion was slowly increasing in size. There was no history of similar lesions elsewhere on the scalp or on the body. On examination, a single skin colored, firm, non-tender 1 cm sized nodule with slight scaling was seen over the left parietal scalp. There was no umbilication. Hair follicles were seen emerging from the nodule [Figure 1]. Rest of the examination was unremarkable. A biopsy was obtained for histological diagnosis.

Histopathological examination showed focal invagination of the epidermis covered by a parakeratotic plug. It was surrounded by hyperplastic epidermis with papillomatosis and hypergranulosis [Figure 2]. There was a suprabasal cleft with formation of villi protruding into the cleft [Figure 3]. Acantholytic cells could be seen in the cleft along with the presence of dyskeratotic cells [Figure 4]. Mild lymphocytic infiltrate was seen in the superficial dermis.

WHAT IS YOUR DIAGNOSIS?

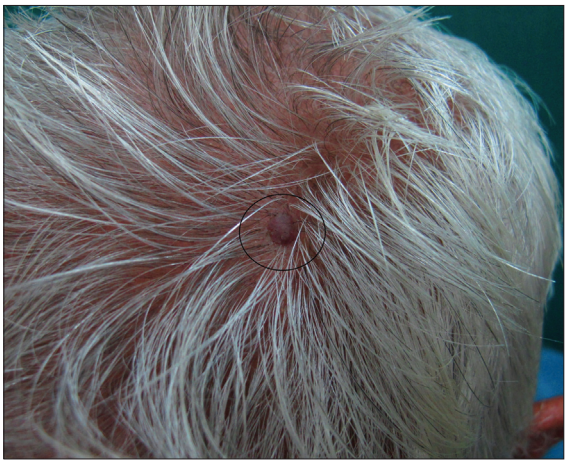

Figure 1: Asymptomatic nodule on the scalp

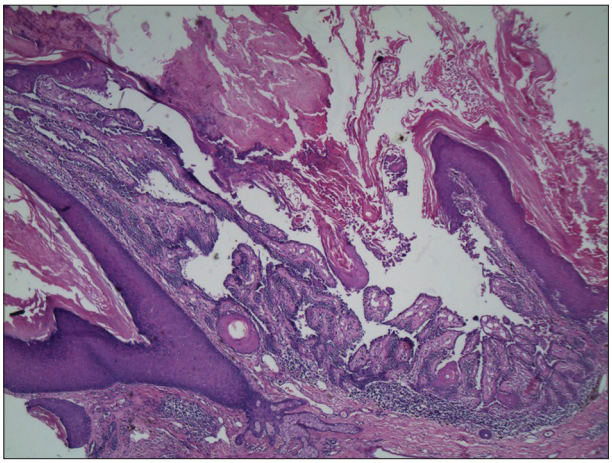

Figure 2: Focal invagination of the epidermis with parakeratotic plug (H and E, ×100)

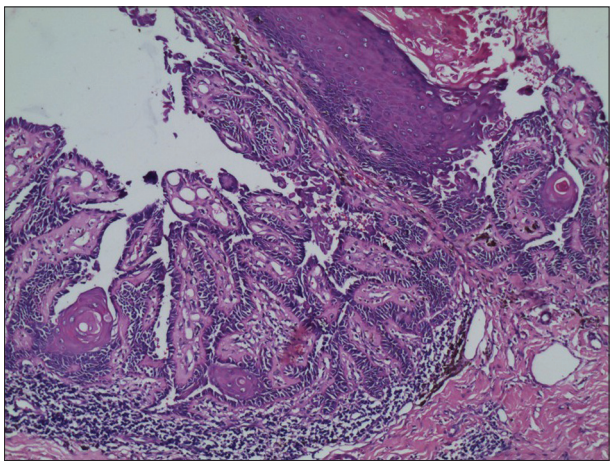

Figure 3: Suprabasal cleft with formation of villi protruding into the cleft (H and E, ×200)

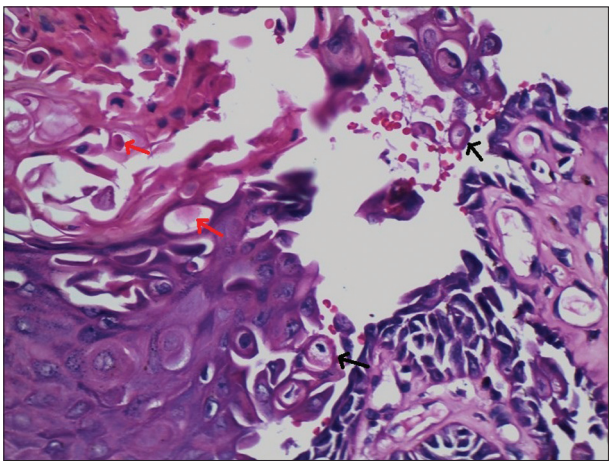

Figure 4: Presence of acantholytic (black arrows) and dyskeratotic cells (red arrows) (H and E, ×400)

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Answer: Warty dyskeratoma

DISCUSSION

Warty dyskeratoma was first described by Helwig in 1954 and was termed as isolated Darier's disease. The term warty dyskeratoma was later coined by Szymansky in 1957.[1] Warty dyskeratoma commonly manifests as an umbilicated lesion with a keratotic plug, usually limited to the head, neck, or face in middle aged individuals. Lesions are generally solitary and rarely multiple. Other sites of involvement like the oral cavity,[2] larynx and genitalia[3] have been described in literature. Rarely, subungual presentation has been documented.[4] One case presented as a longitudinal red ridge within the nail plate.[2]

Histopathological examination characteristically shows the presence of acantholytic dyskeratosis leading to a suprabasal cleft. Three architectural patterns have been recognized: cup-shaped, cystic and nodular.[1] The cup-shaped pattern is the commonest and shows the presence of a cup like invagination of the epidermis, which is lined by acanthotic epidermis with papillomatosis. A parakeratotic plug is present overlying the invagination. The cystic pattern consists of large, well circumscribed nodules in the papillary and upper reticular dermis composed of keratin cysts lined by a proliferation of epithelial cells. Nodular lesions are composed of small, well circumscribed, solid aggregates of epithelial cells in the papillary and upper reticular dermis.

The main histological differential diagnoses of warty dyskeratoma include Darier's disease, acantholytic squamous cell carcinoma and Hailey–Hailey disease. Darier's disease shows the presence of suprabasal split with peculiar form of dyskeratosis leading to formation of corps ronds and grains. Acantholytic SCC shows other features of SCC like abnormal proliferation of highly eosinophilic keratinocytes, atypia, abnormal mitoses etc. Hailey–Hailey disease shows a characteristic 'dilapidated brick wall' appearance.

Surgical excision is the treatment of choice.

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