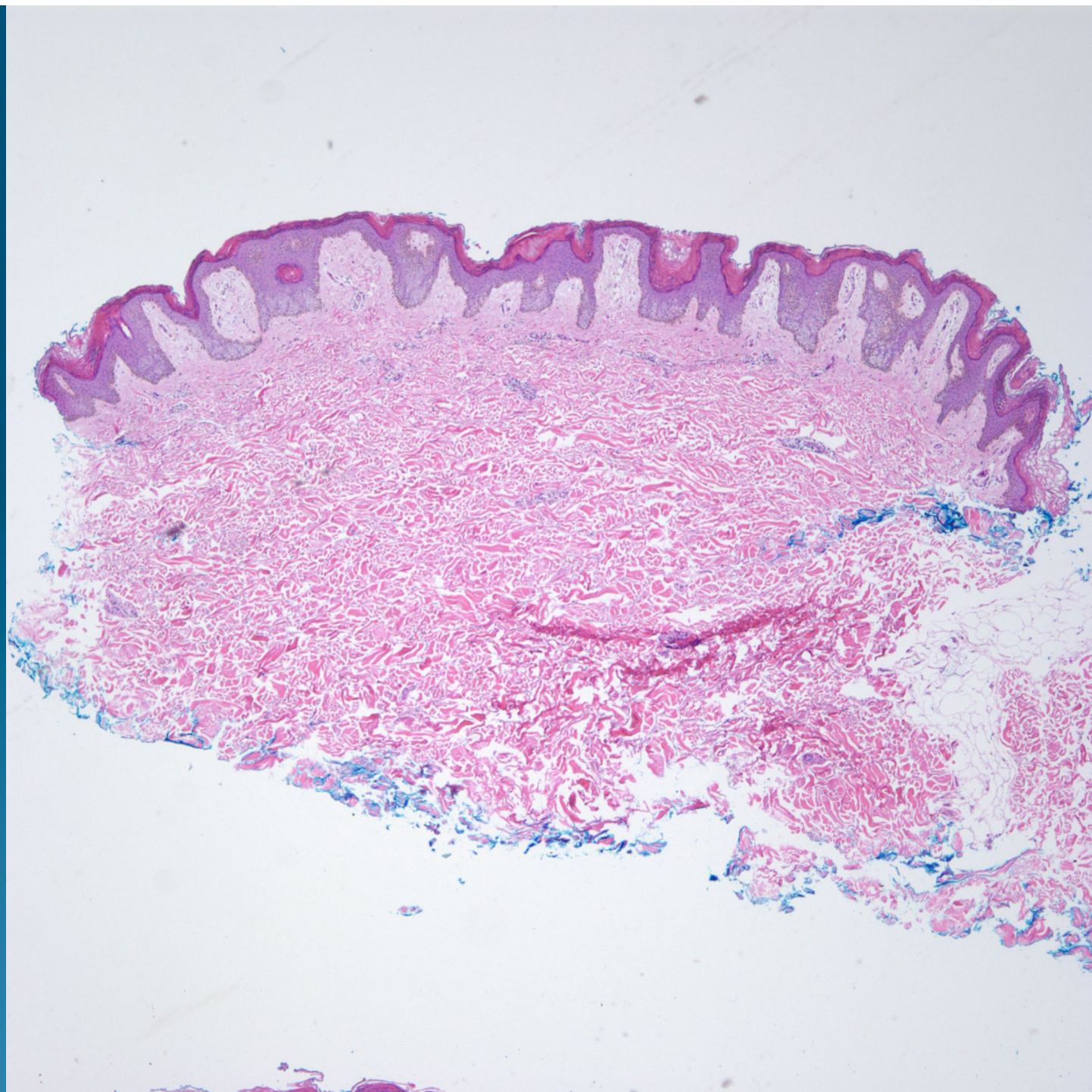
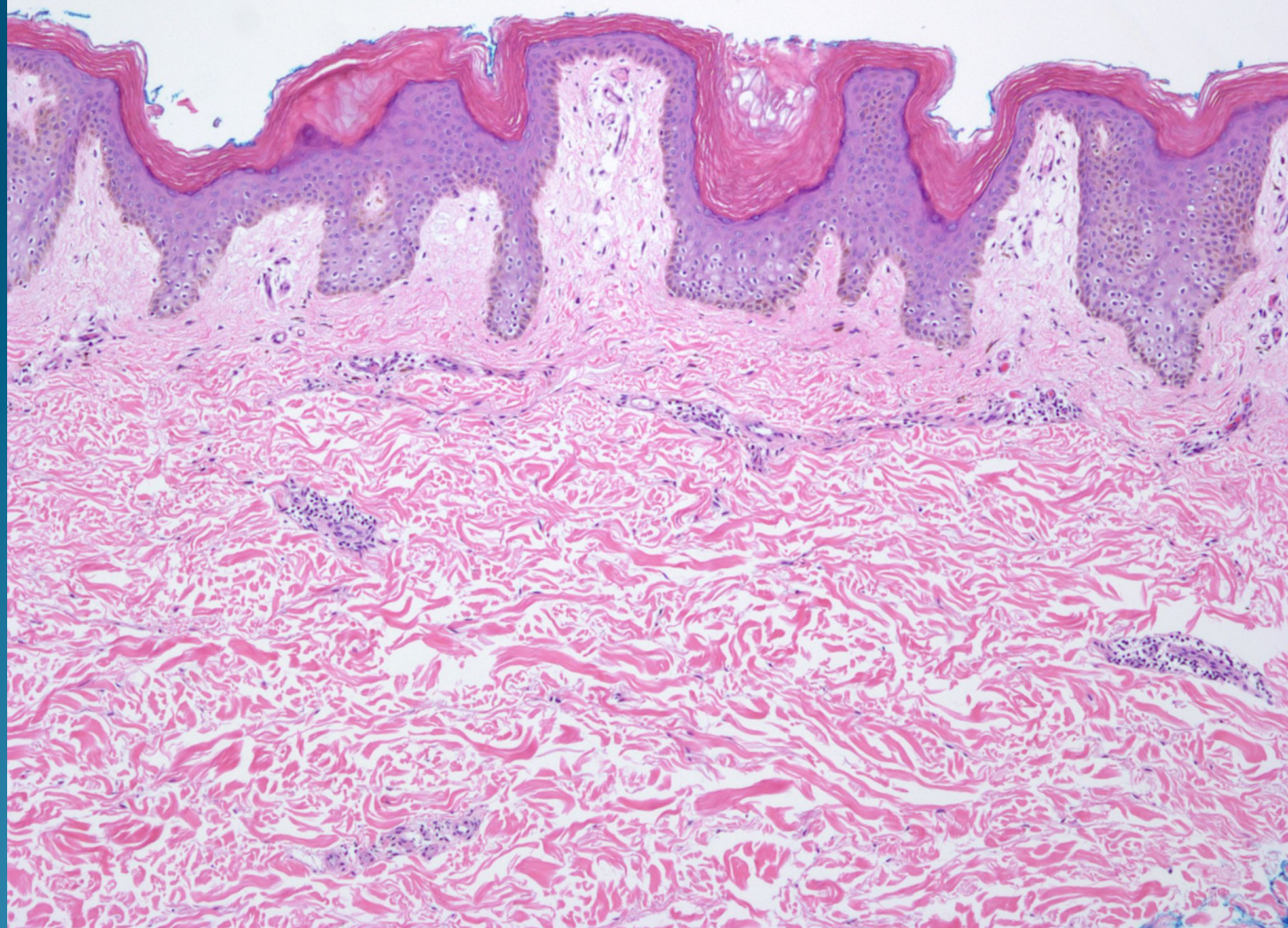
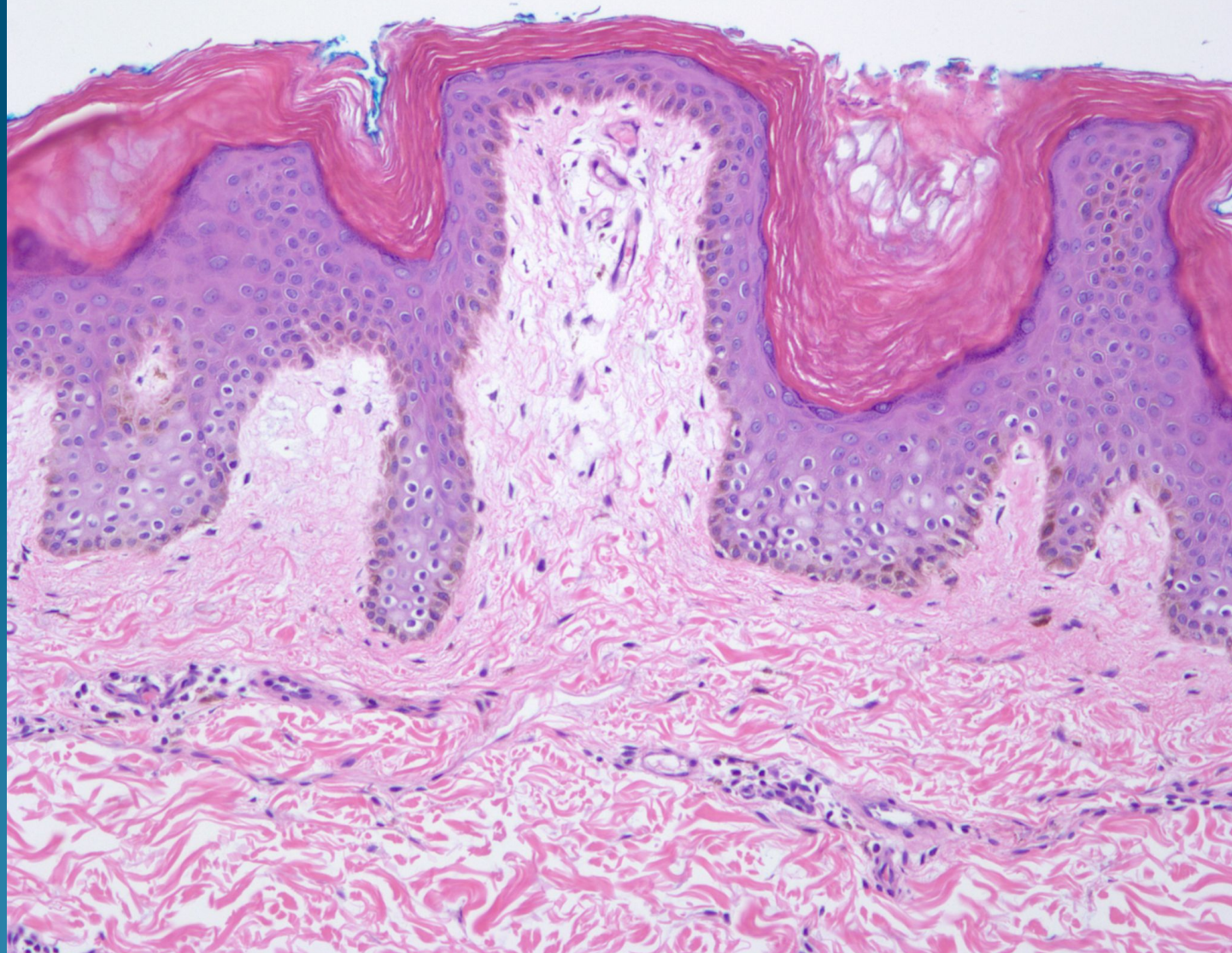


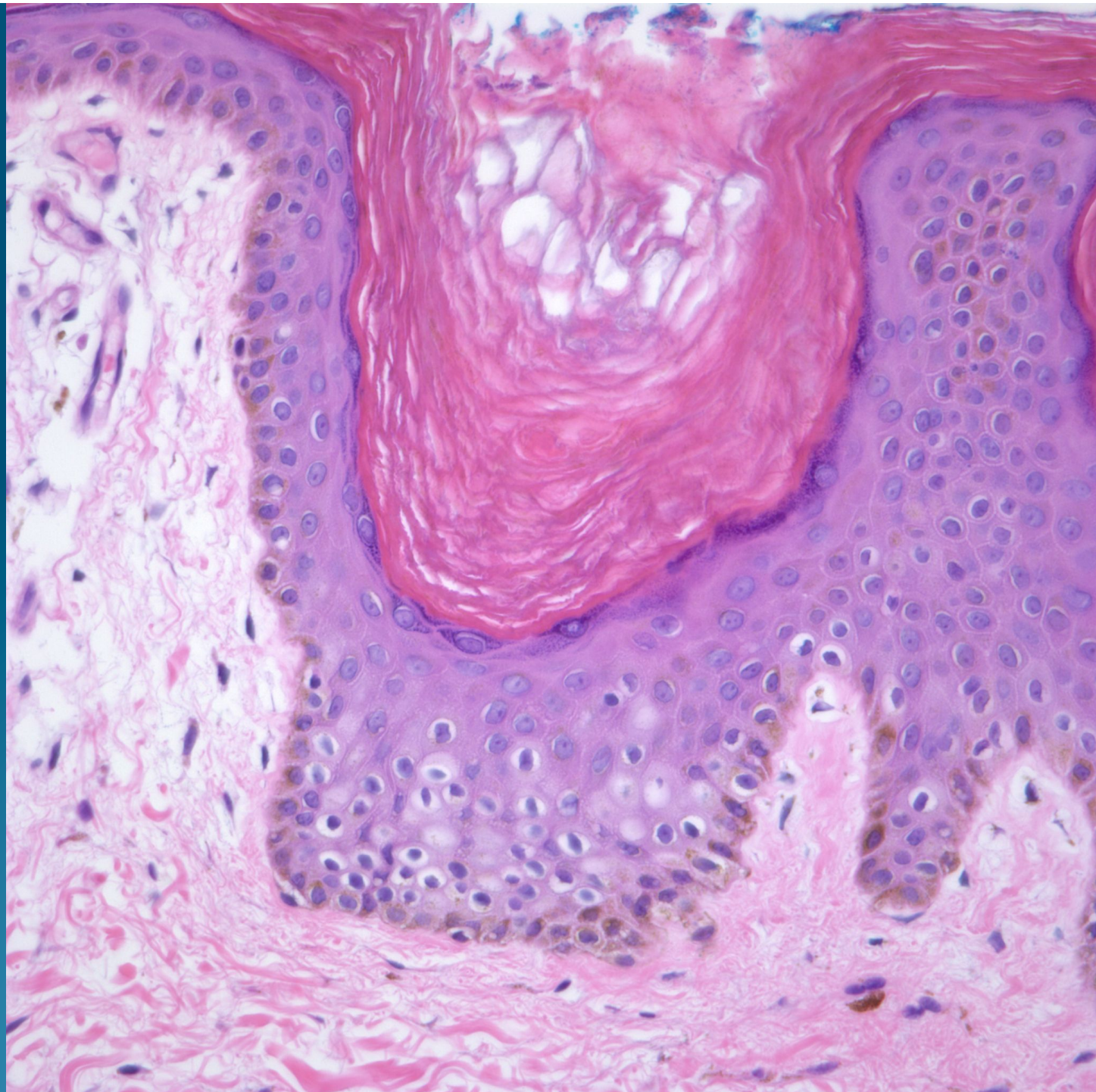
Dermatopathology Slide Review Part 131

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Torrance, CA









Pertinent differential diagnostic considerations include all except:

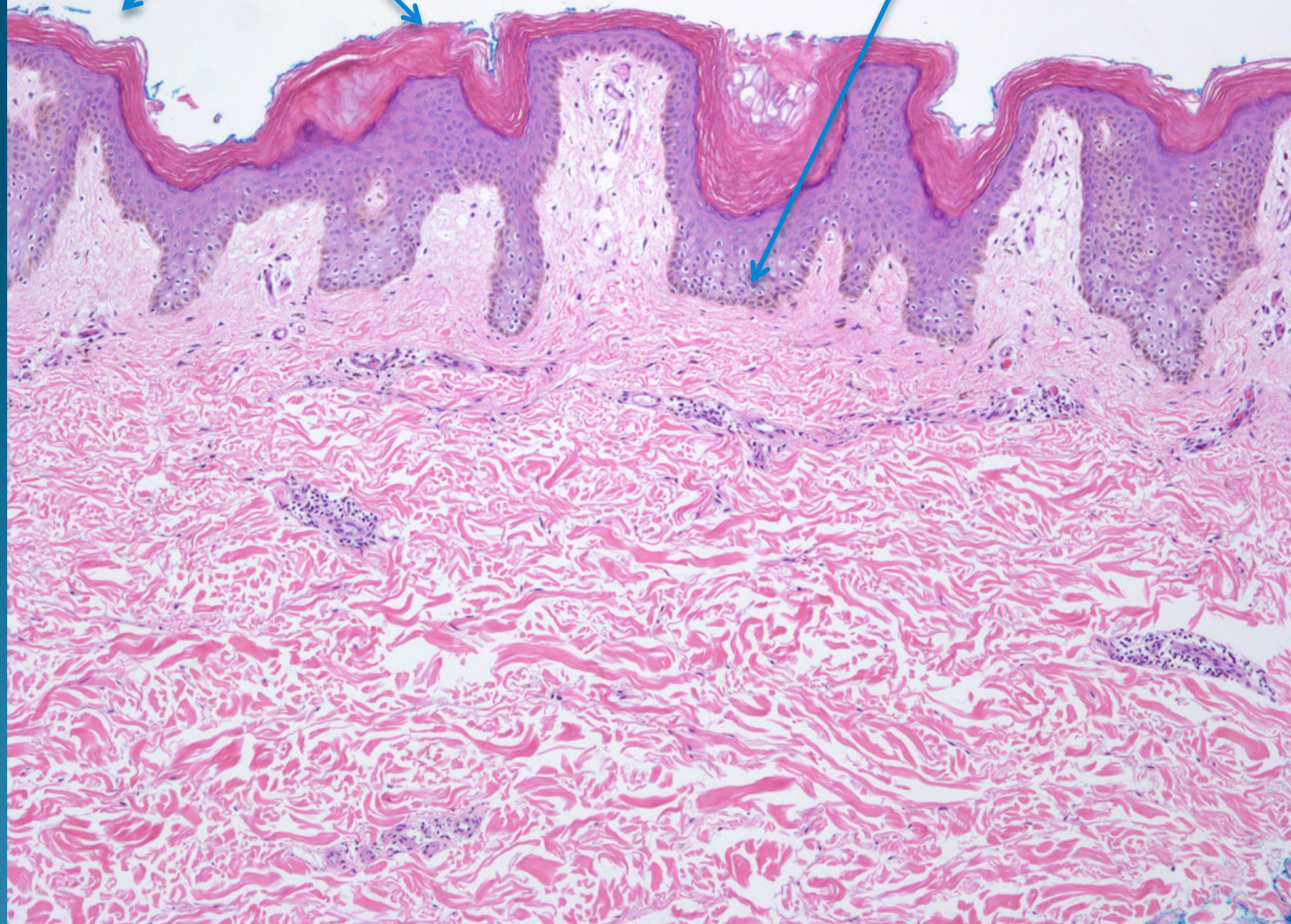
- A. Seborrheic keratosis
- B. Epidermal nevus
- C. Hidroacanthoma simplex
- D. Acanthosis nigricans
- E. Stucco keratosis

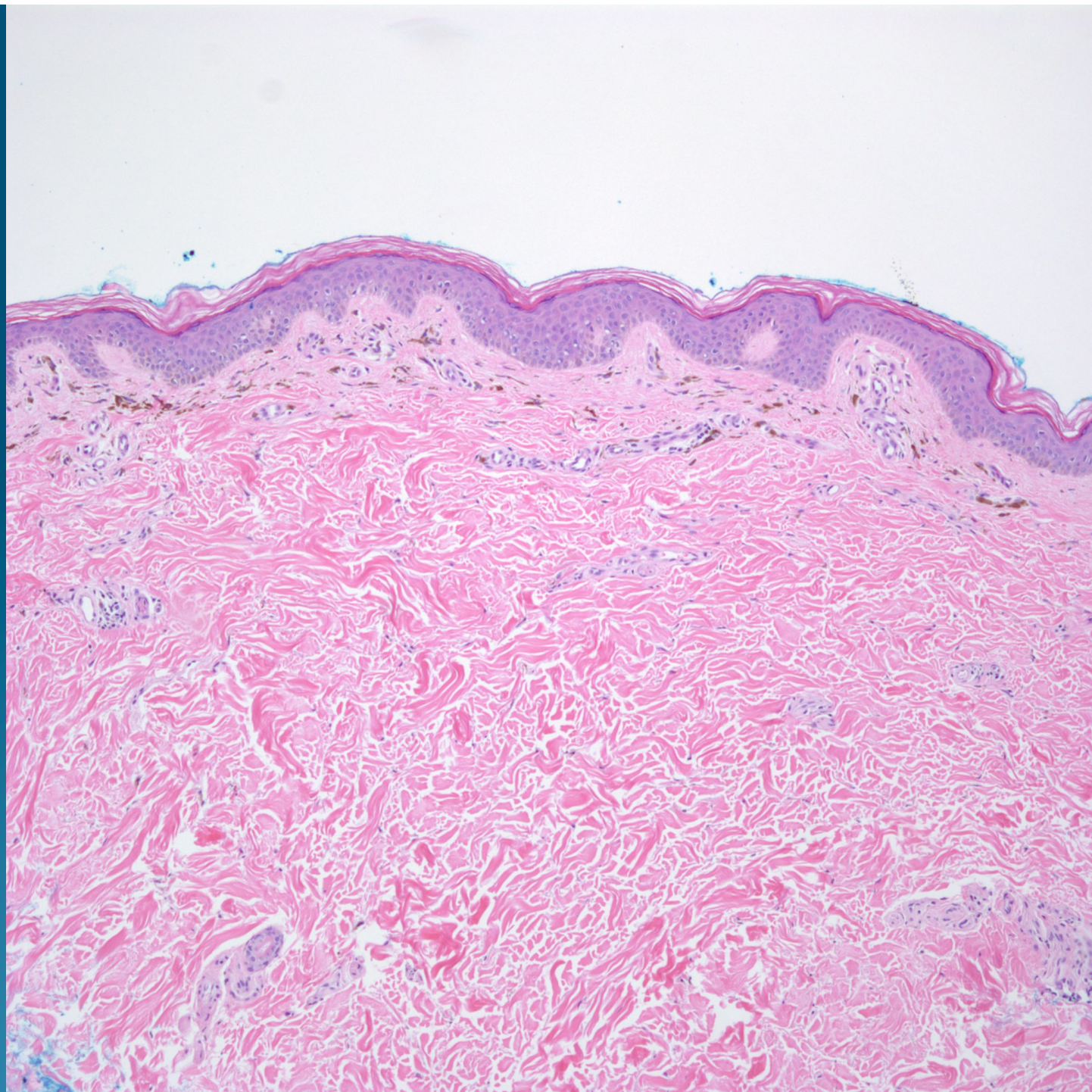
Hidroacanthoma Simple

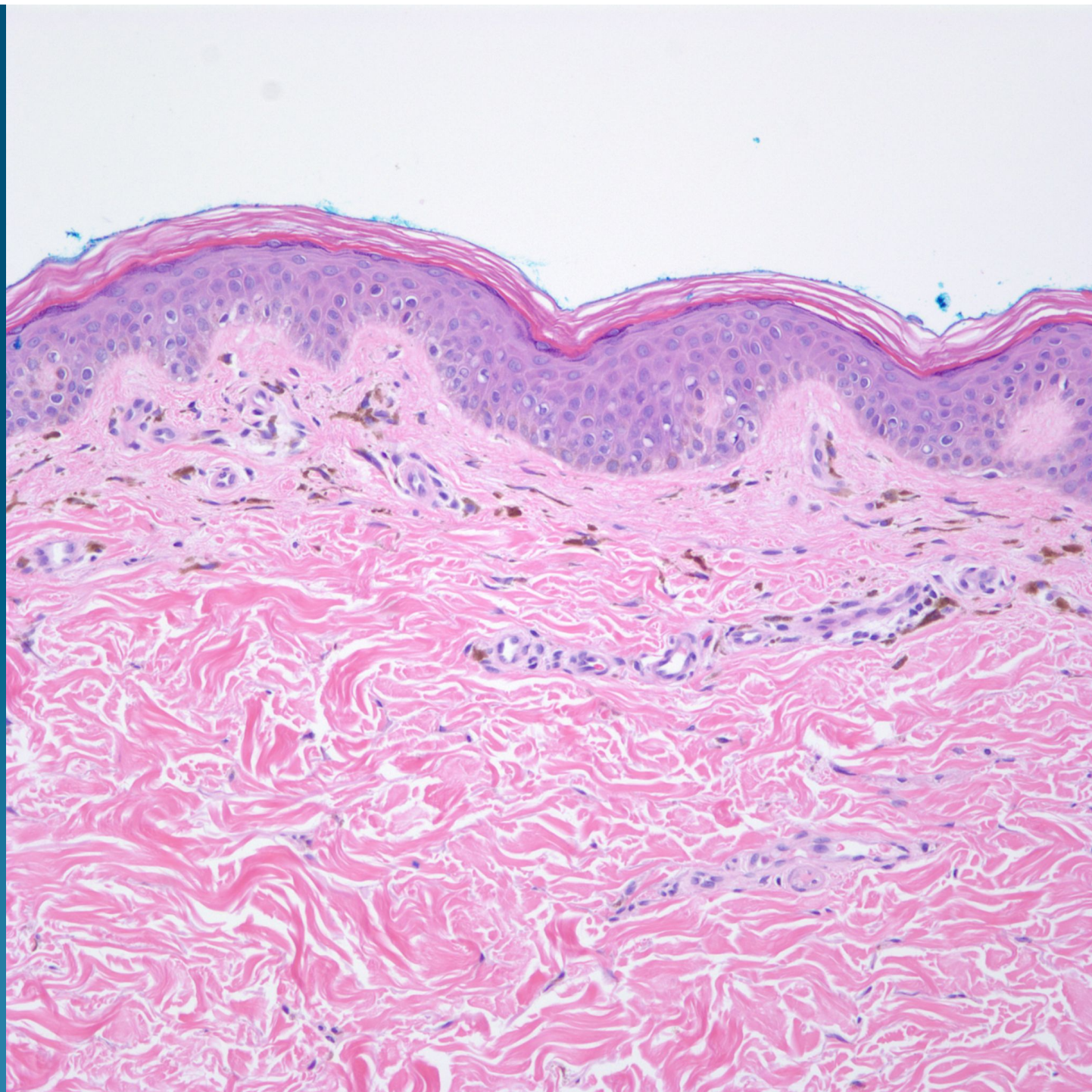
- This is an example of acanthosis nigricans.
- The histopathological changes are subtly different from a seborrheic keratosis with less of a “stuck-on” flattened rete ridge pattern and slight papillomatosis
- Ultimately, clinical correlation may be necessary

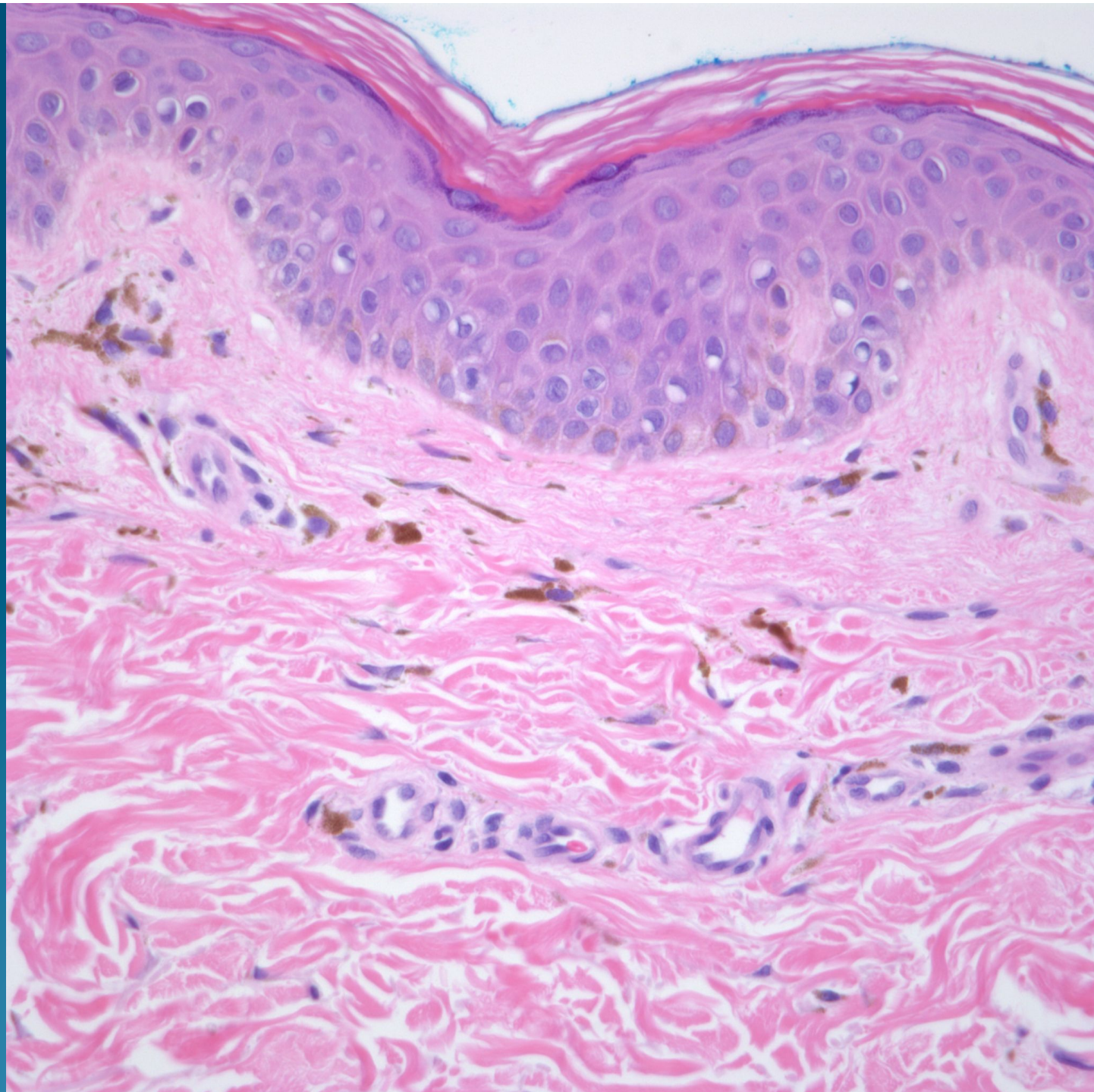
Slight papillomatosis

Rete ridge elongation
With increased melanin
pigmentation









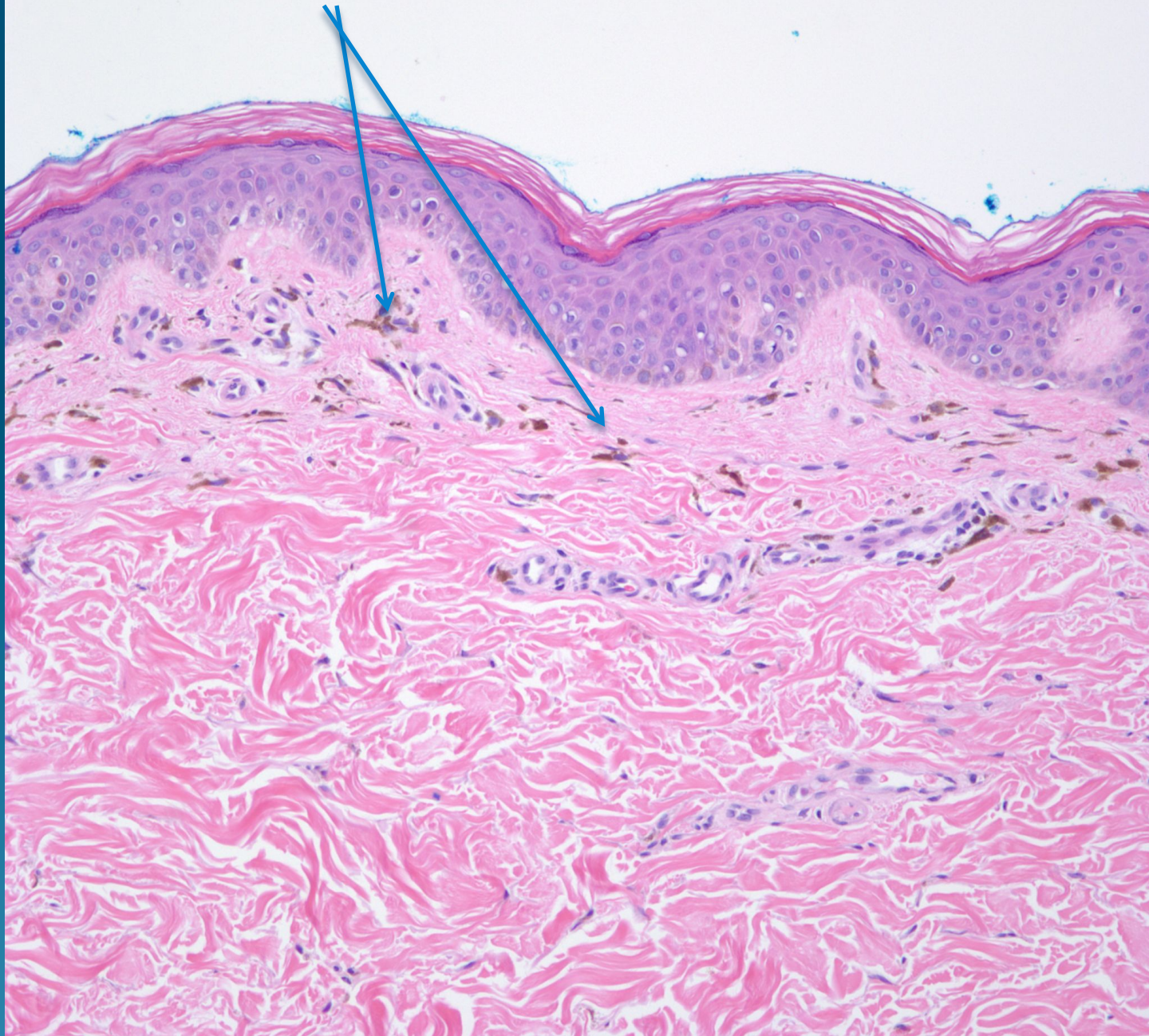
Relevant differential diagnostic considerations for this lesion include all except:

- A. Macular amyloidosis
- B. Ochronosis
- C. Post-inflammatory pigmentary alteration
- D. Ashy dermatosis
- E. Resolving contact dermatitis

Ochronosis

- This is an example of a post-inflammatory pigmentary alteration
- Note the dermal papillary melanophages-these histopathological findings may be seen in clinically hyperpigmented and hypopigmented lesions
- Look carefully to exclude hyaline deposits at the DE junction, a hallmark of macular amyloidosis
- Resolving dermatoses including a contact dermatitis may present with similar histopathology

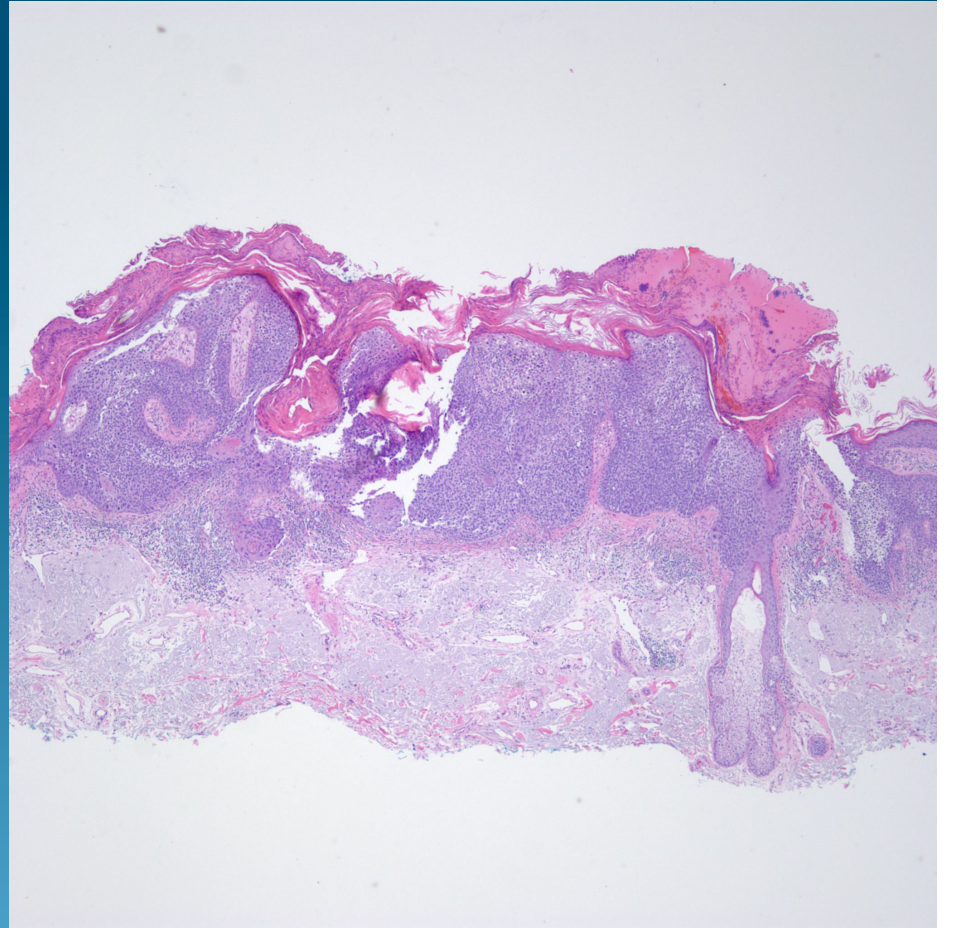
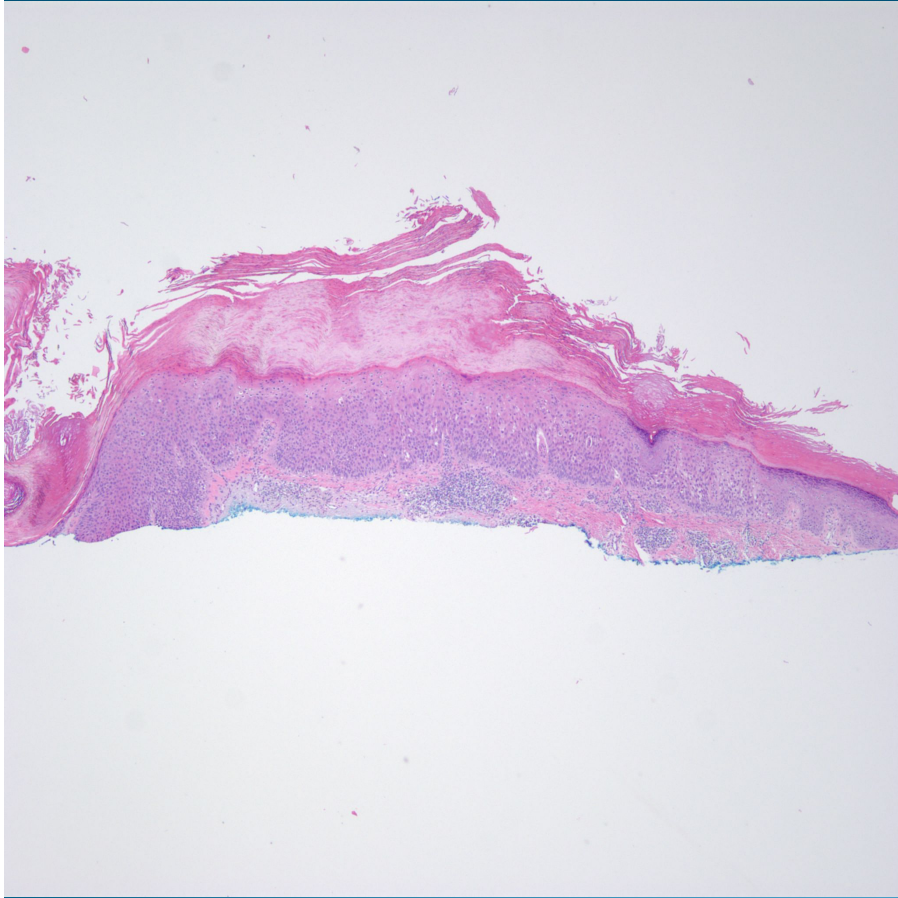
Scattered dermal melanophages

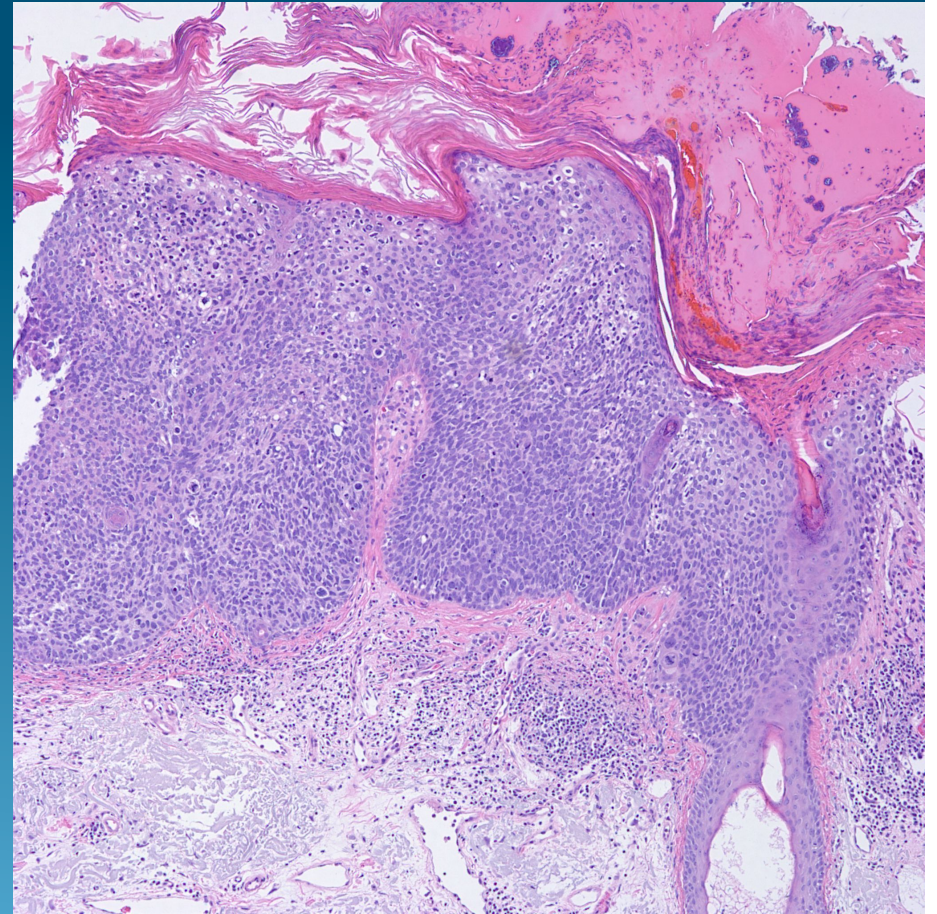
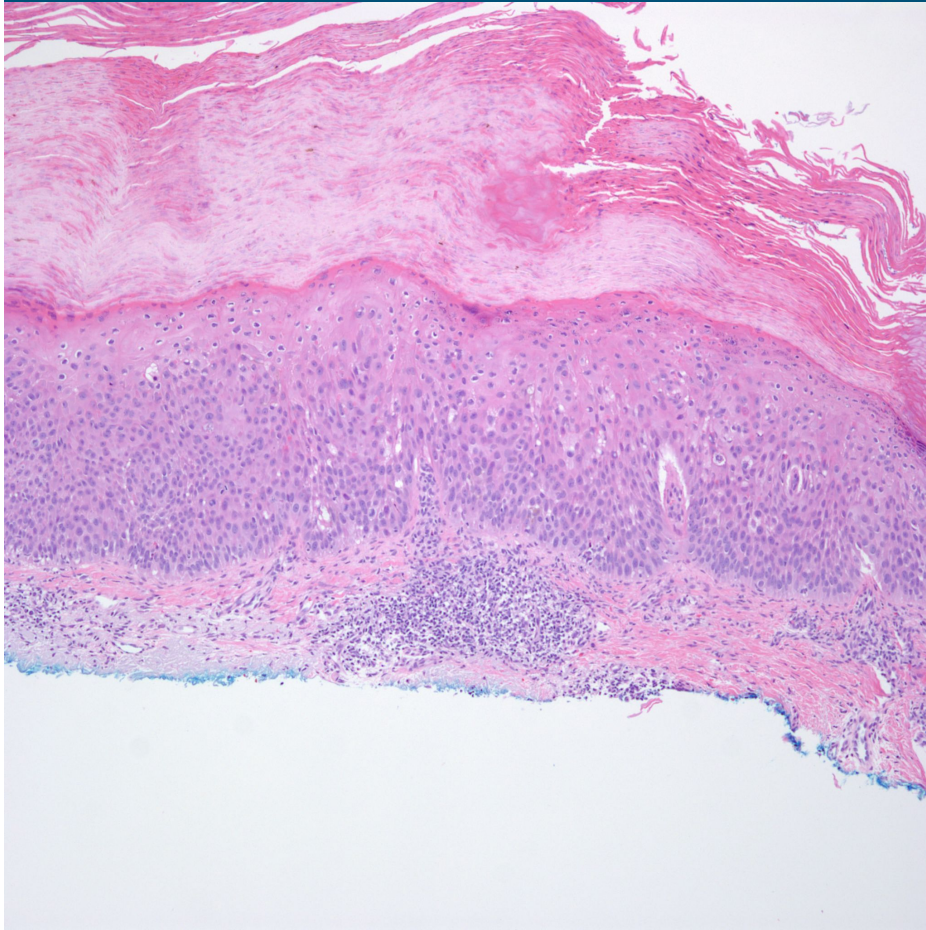


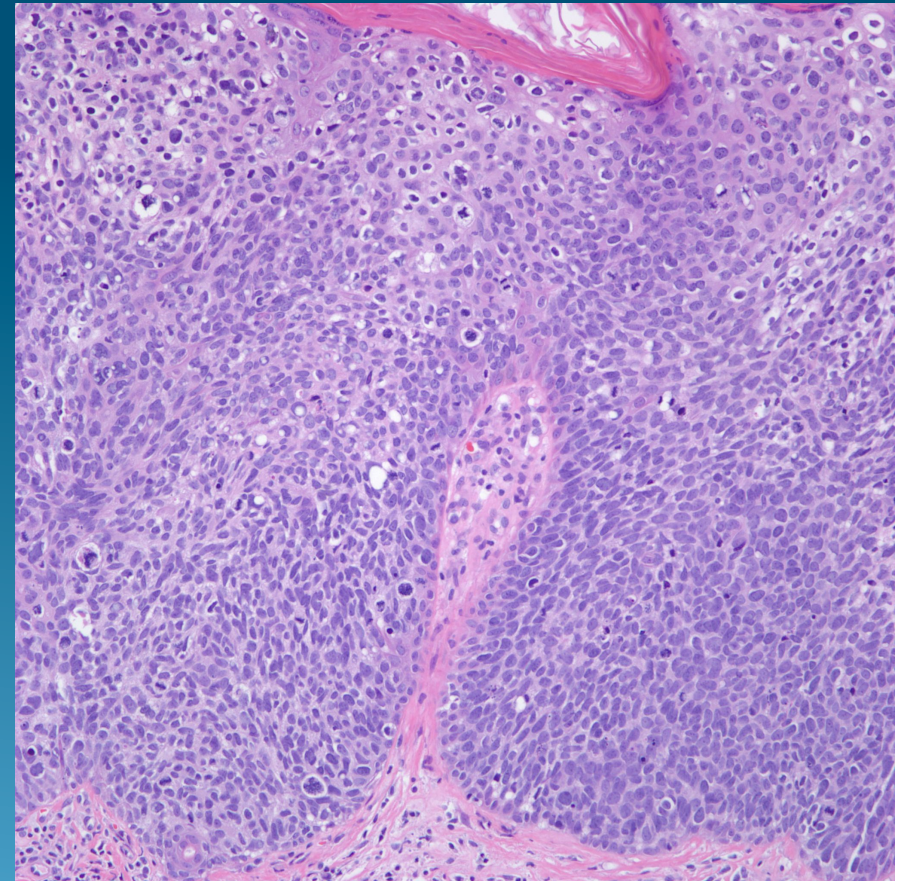
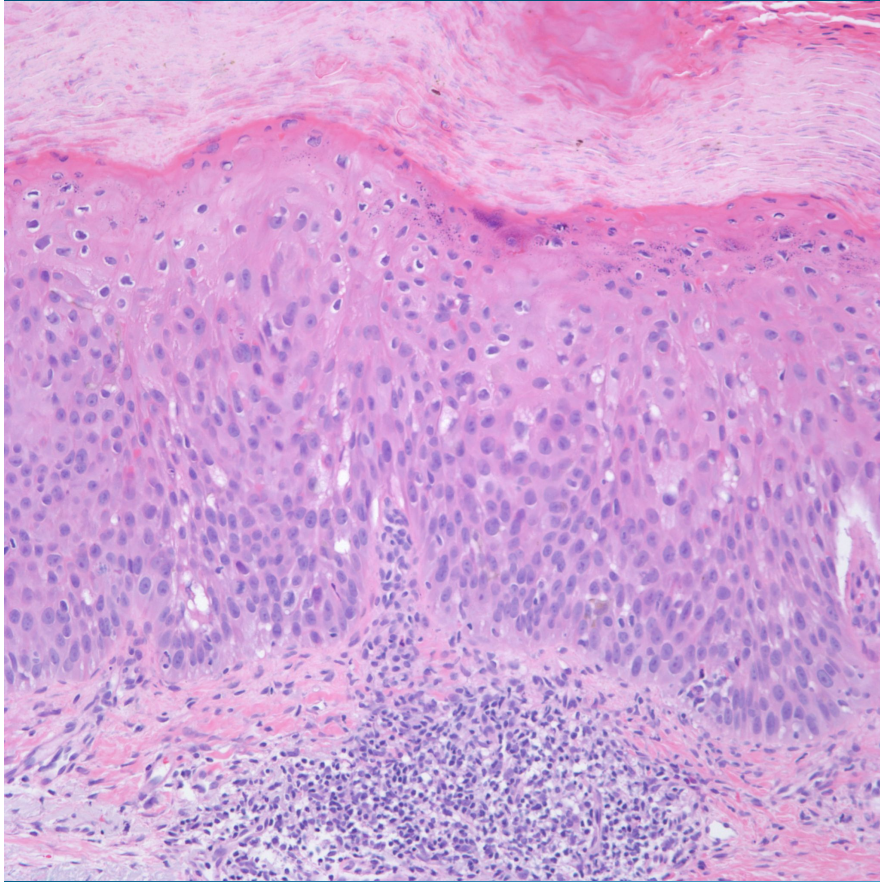
Differential Diagnosis

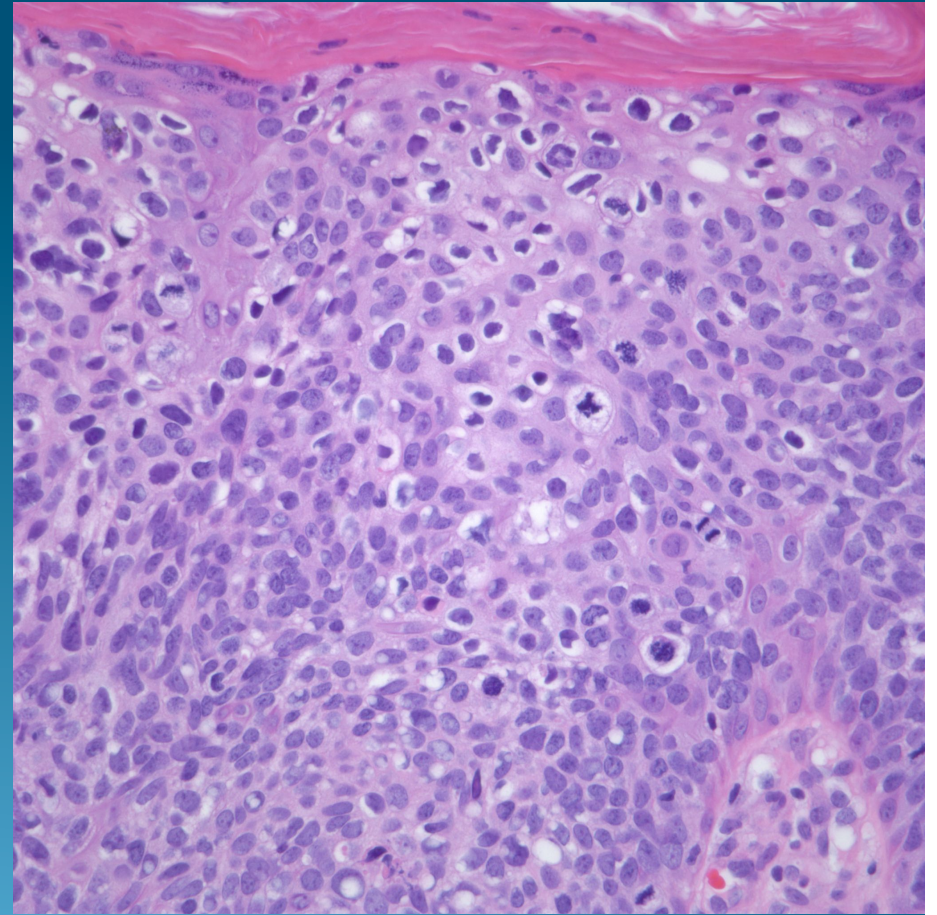
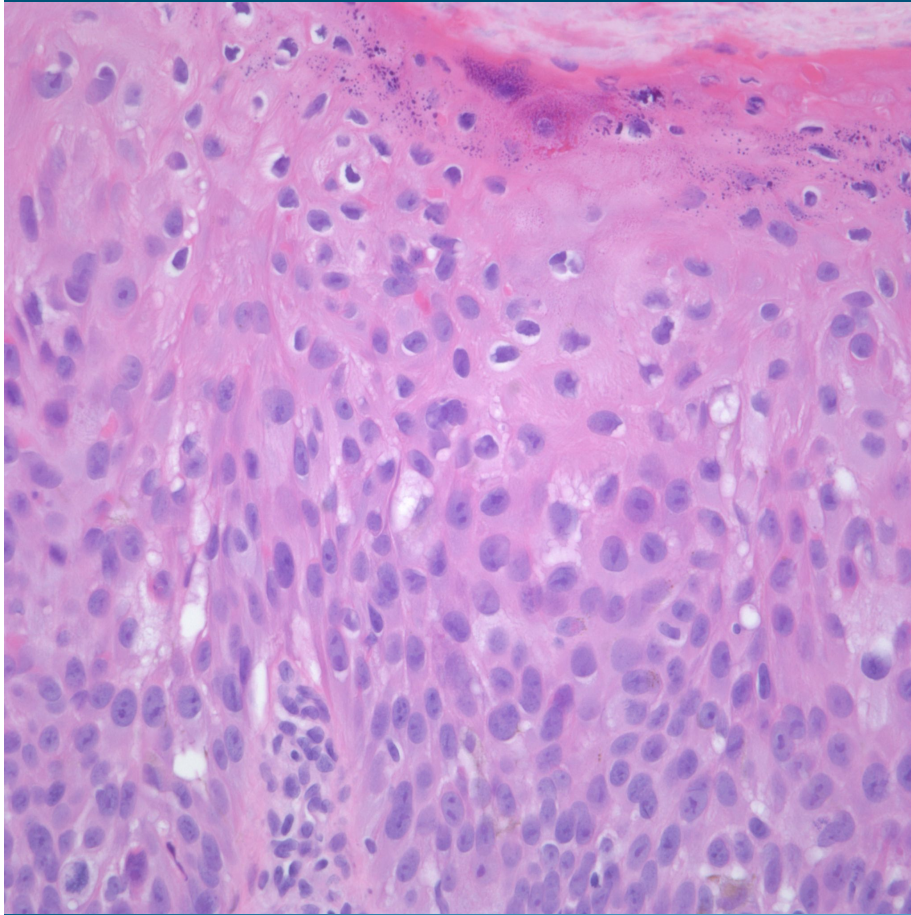
Hyperplastic Actinic Keratosis or Squamous Cell Carcinoma in Situ?*

*Each side of the screen is the same lesion photographed at increasing magnifications.



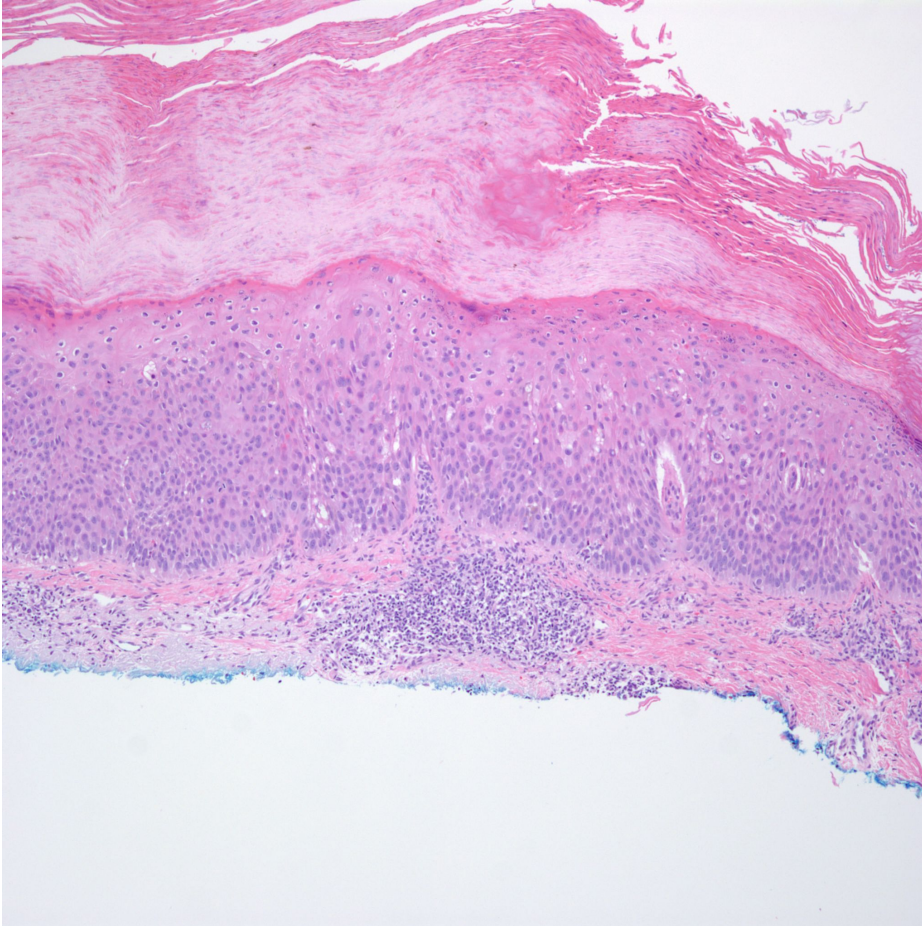




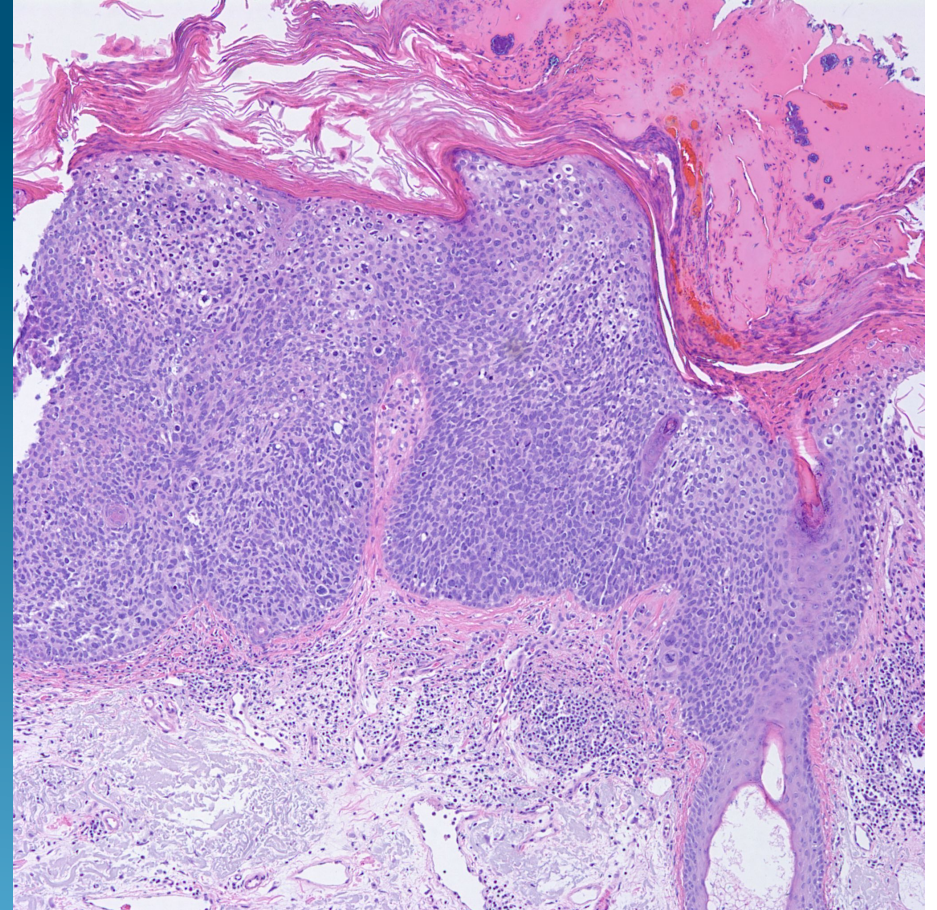


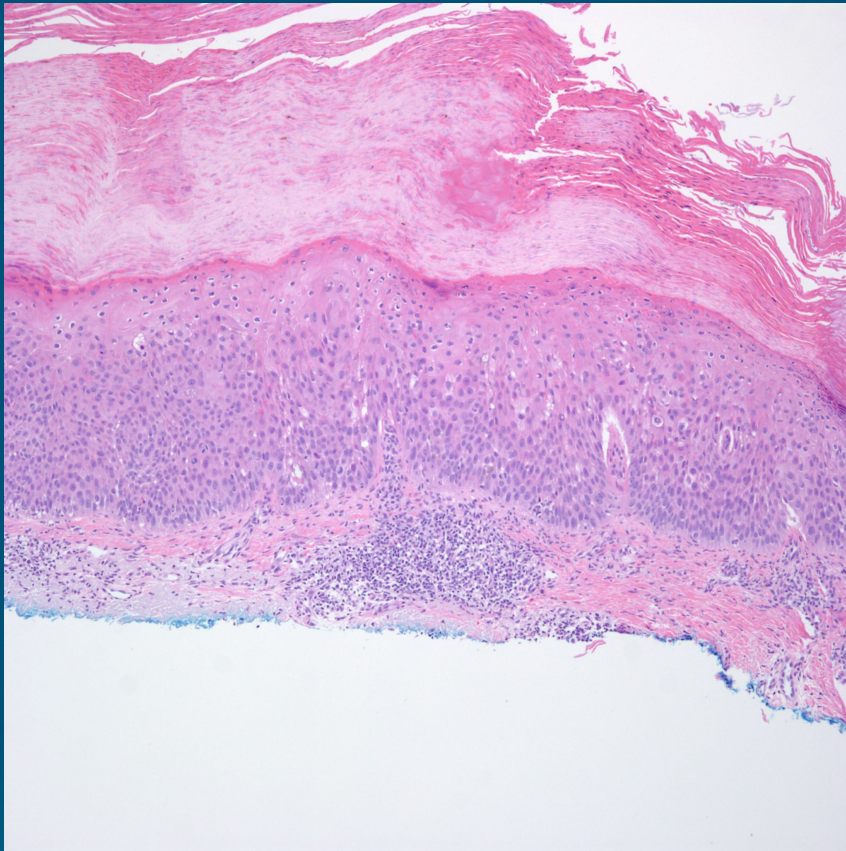
Hyperplastic Actinic Keratosis or Squamous Cell Carcinoma in Situ?

Hyperplastic Actinic Keratosis

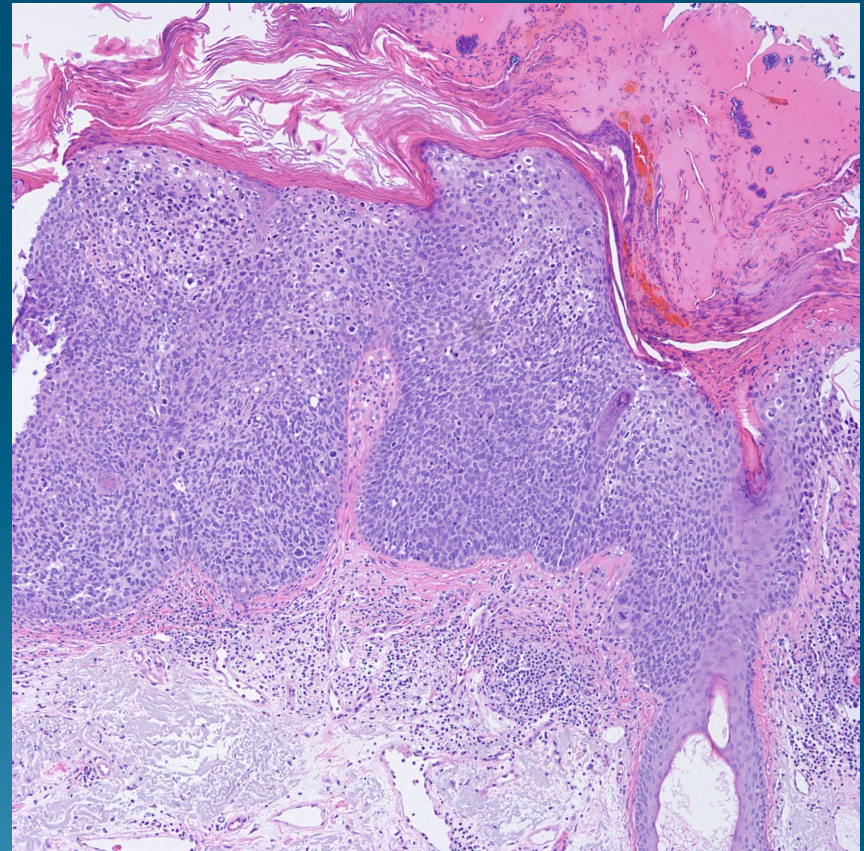


Squamous Cell Carcinoma in Situ

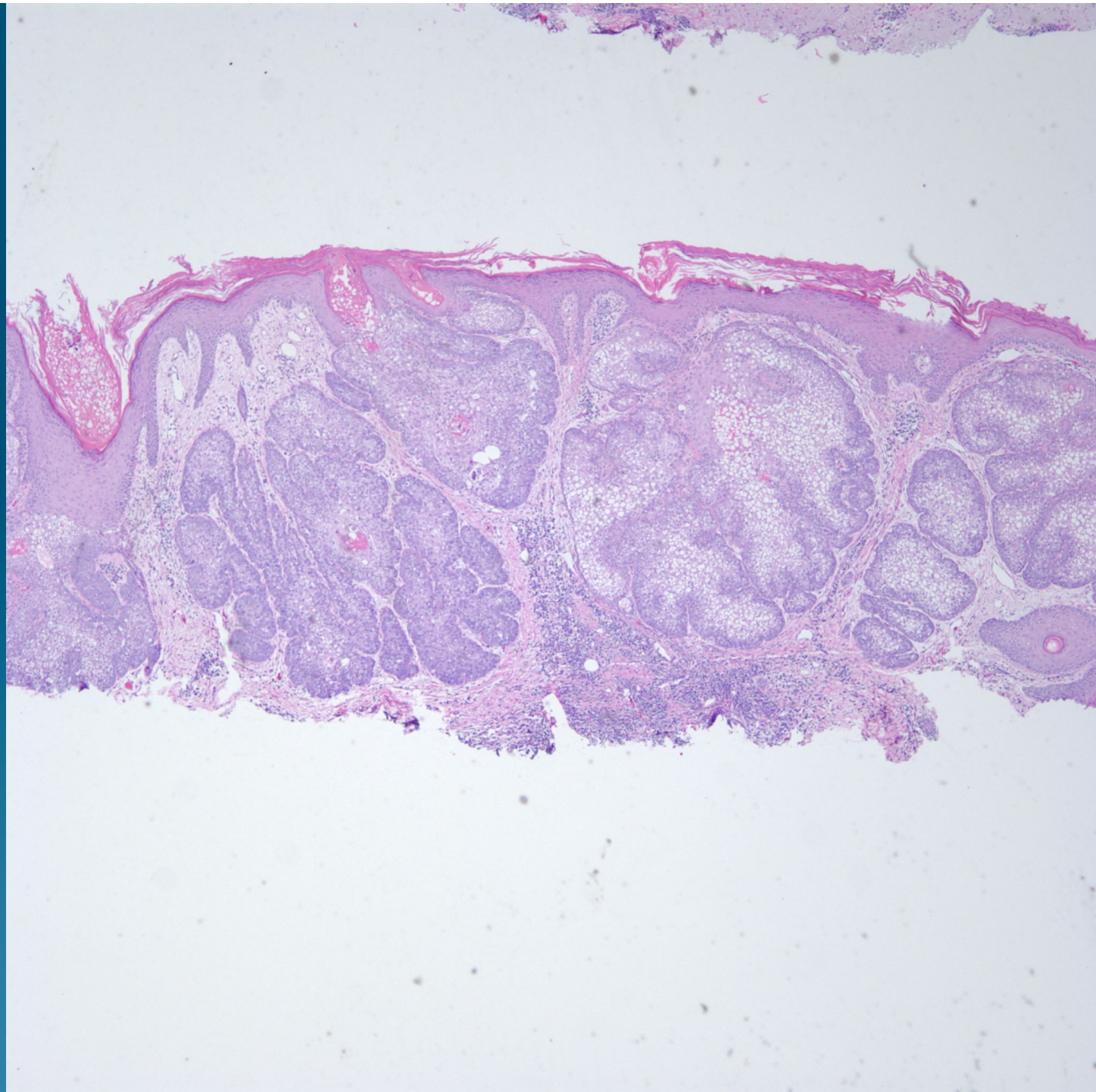


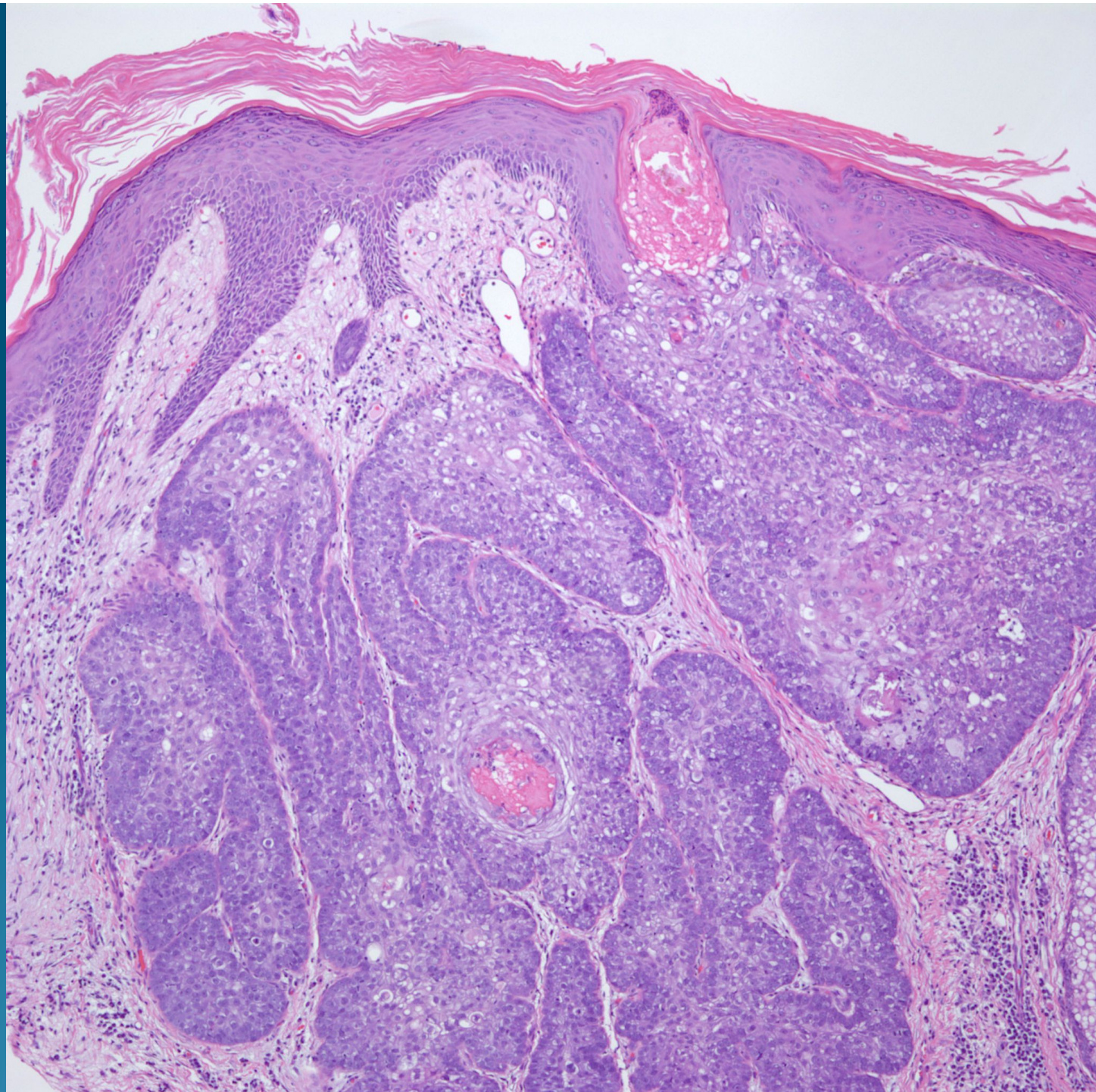


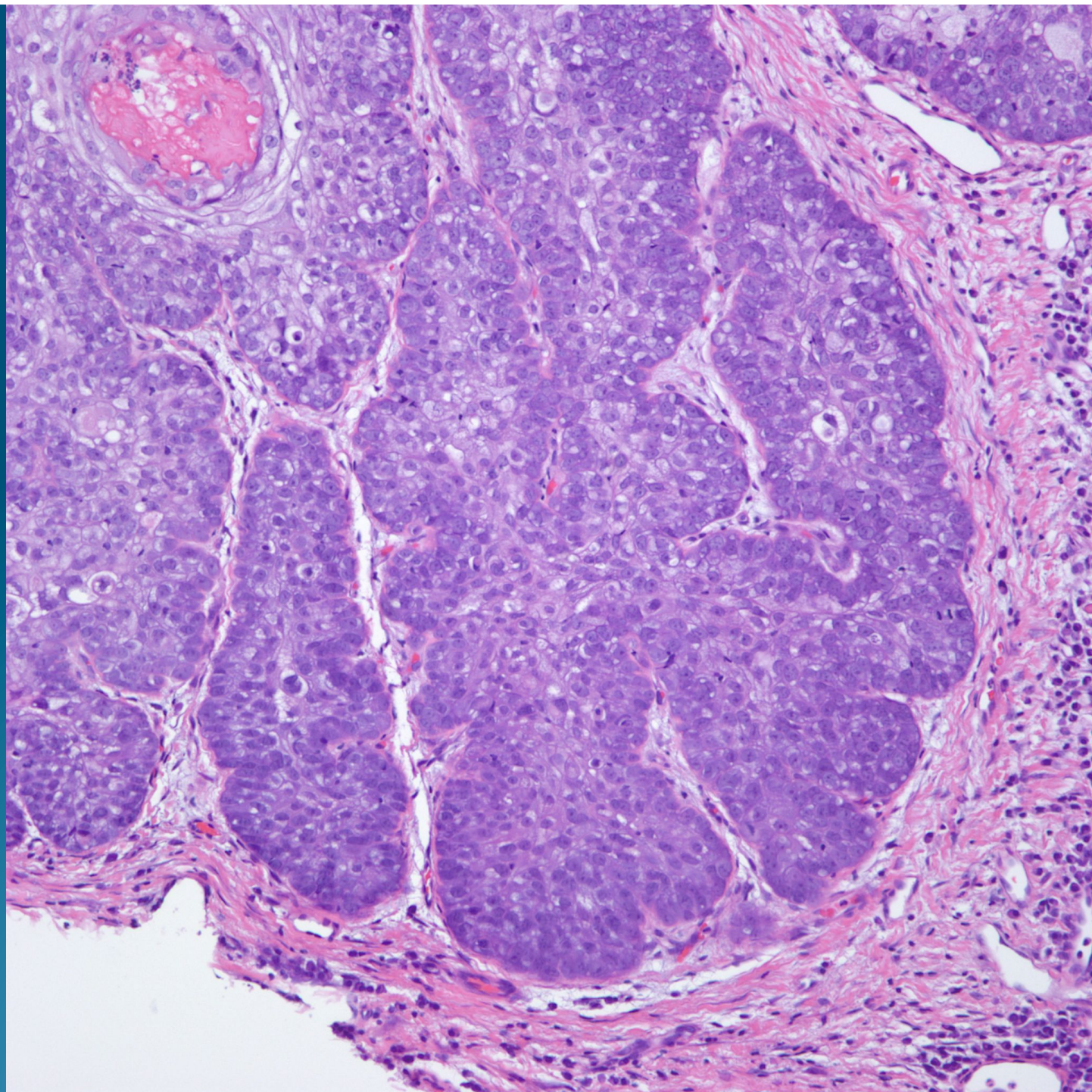
Near full thickness epidermal replacement
By atypical keratinocytes
Sparing of the follicular infundibulum

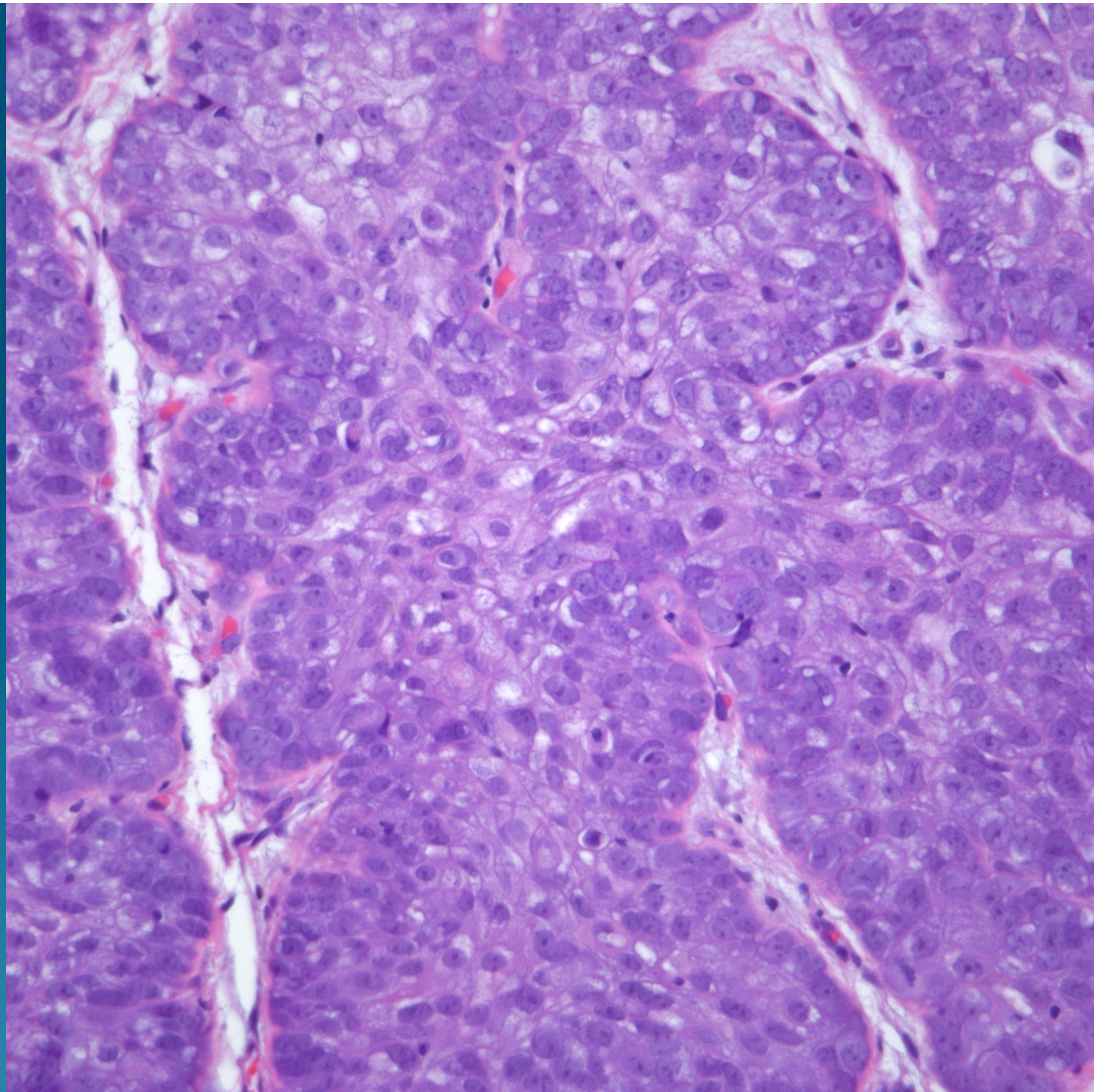


Full thickness replacement of epidermis
By atypical keratinocytes
No sparing of the follicular infundibulum
Loss of polarity of keratinocytes
Atypical mitotic figures
Dyskeratotic keratinocytes









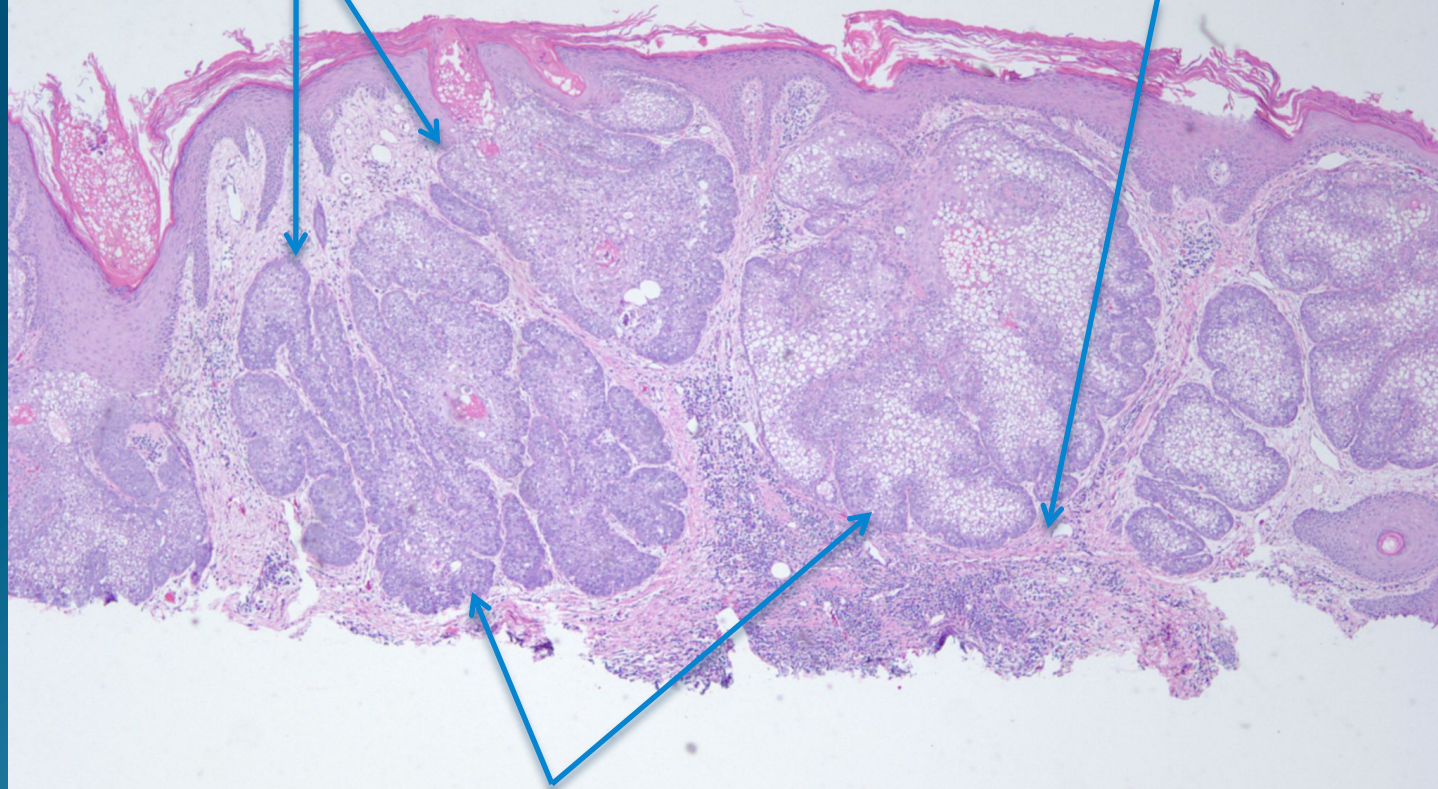
What is the best diagnosis?

- A. Sebaceous carcinoma
- B. Basal cell carcinoma with sebaceous differentiation
- C. Sebaceoma
- D. Eccrine Poroma
- E. Sebaceous gland hyperplasia

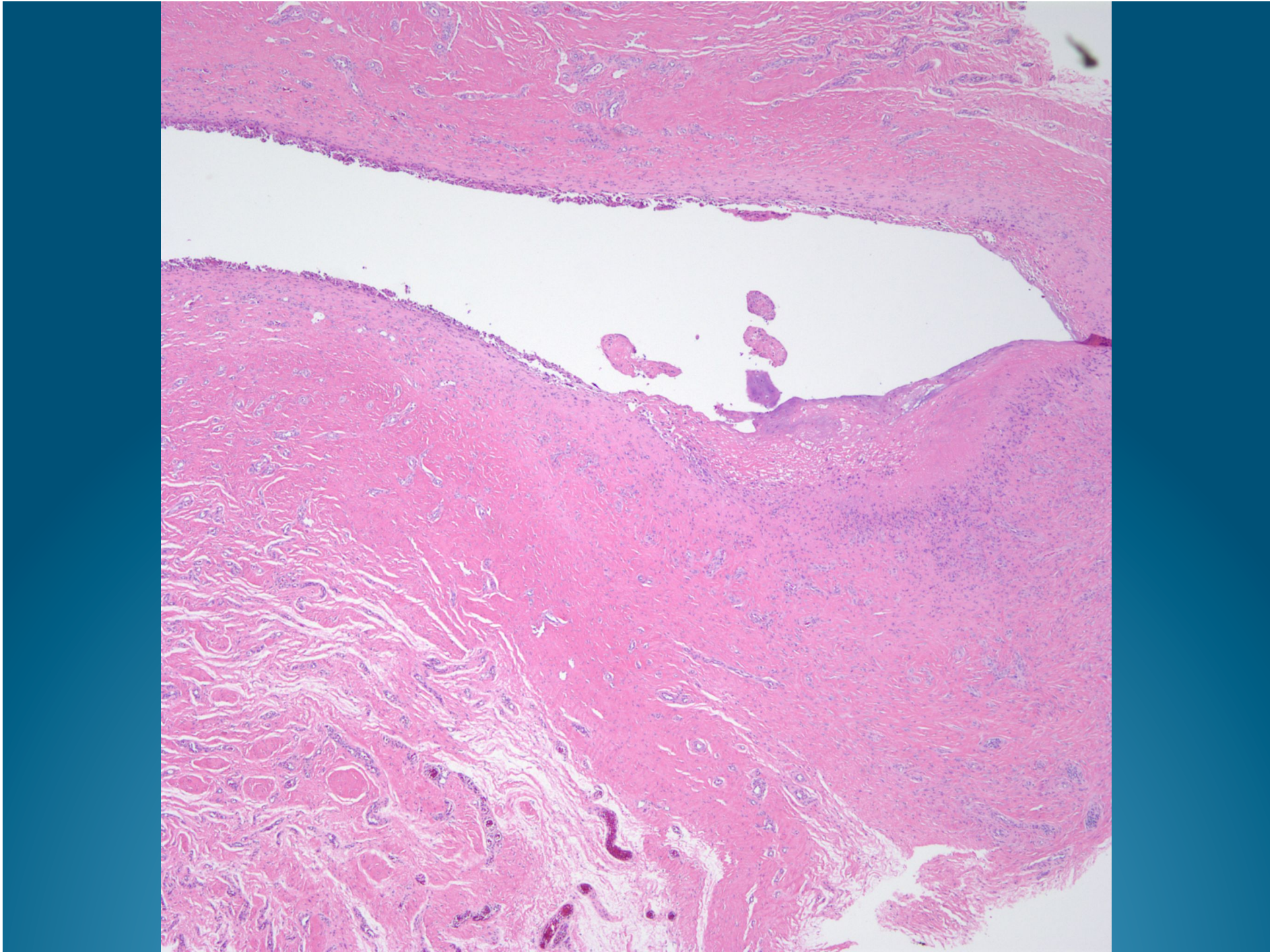
Sebaceous Carcinoma

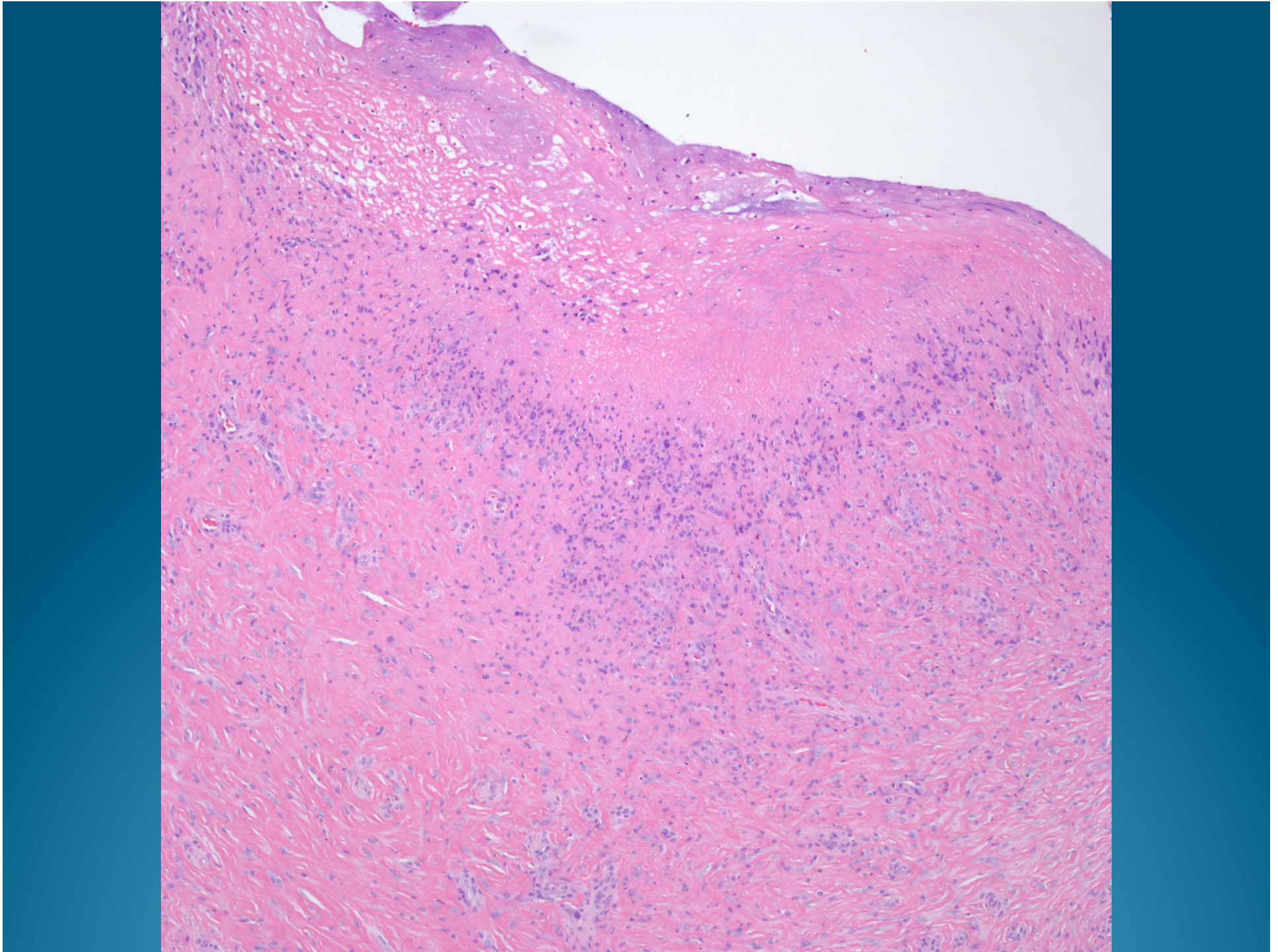
Basaloid cells lacking peripheral palisading
Or stromal-tumor clefting

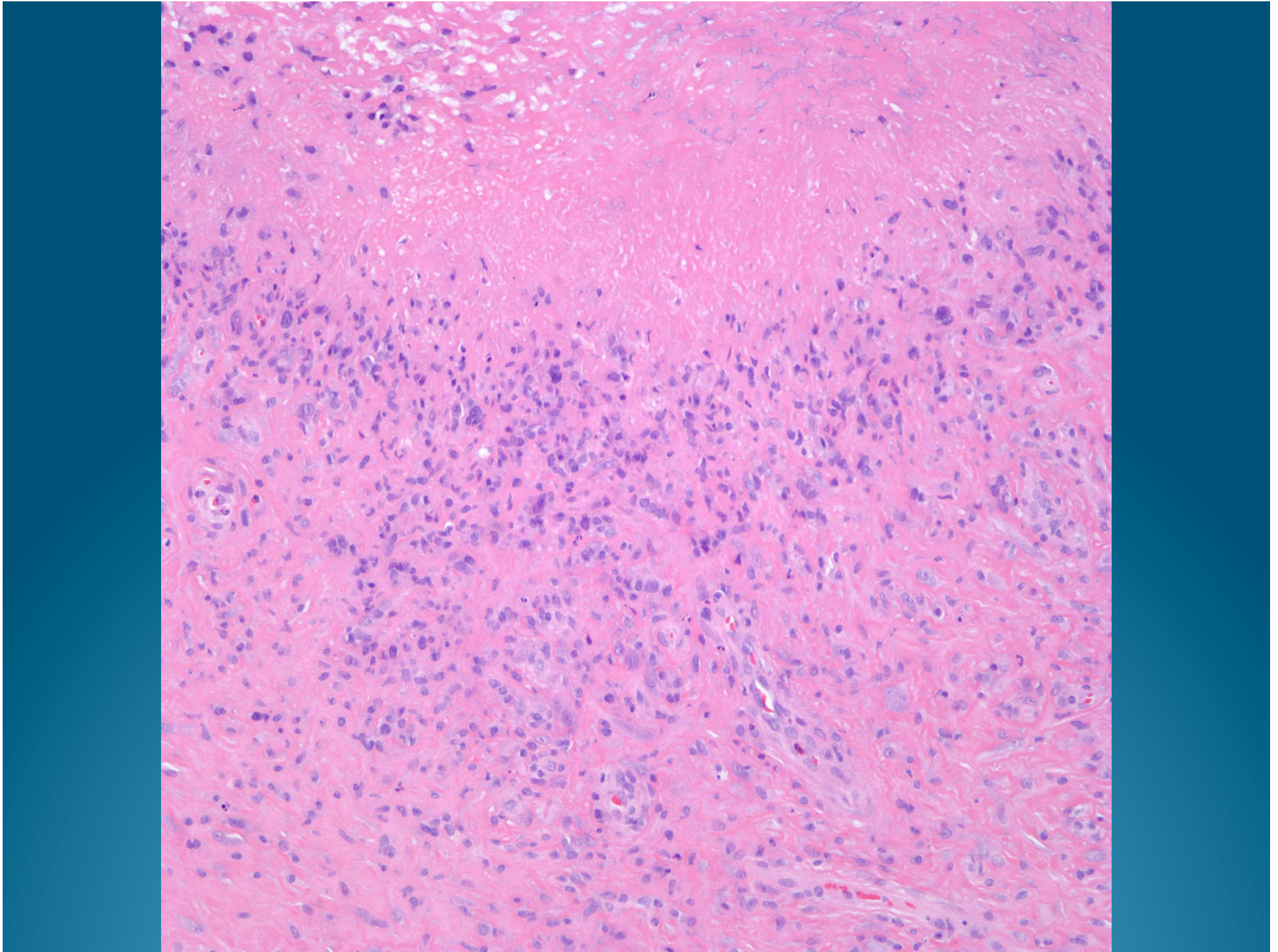
Invasive growth pattern

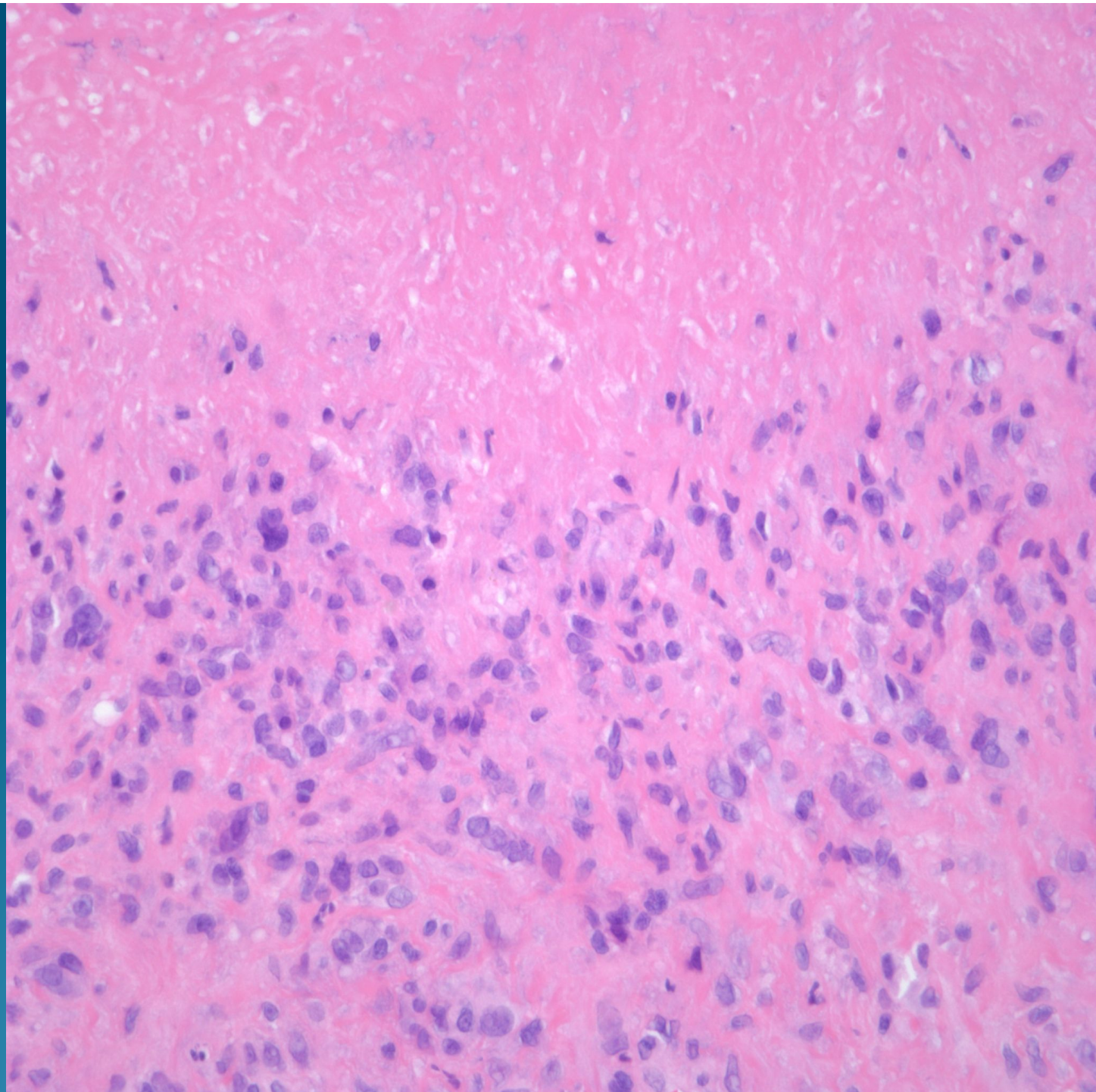


Malignant sebocytes with varying stages of maturation









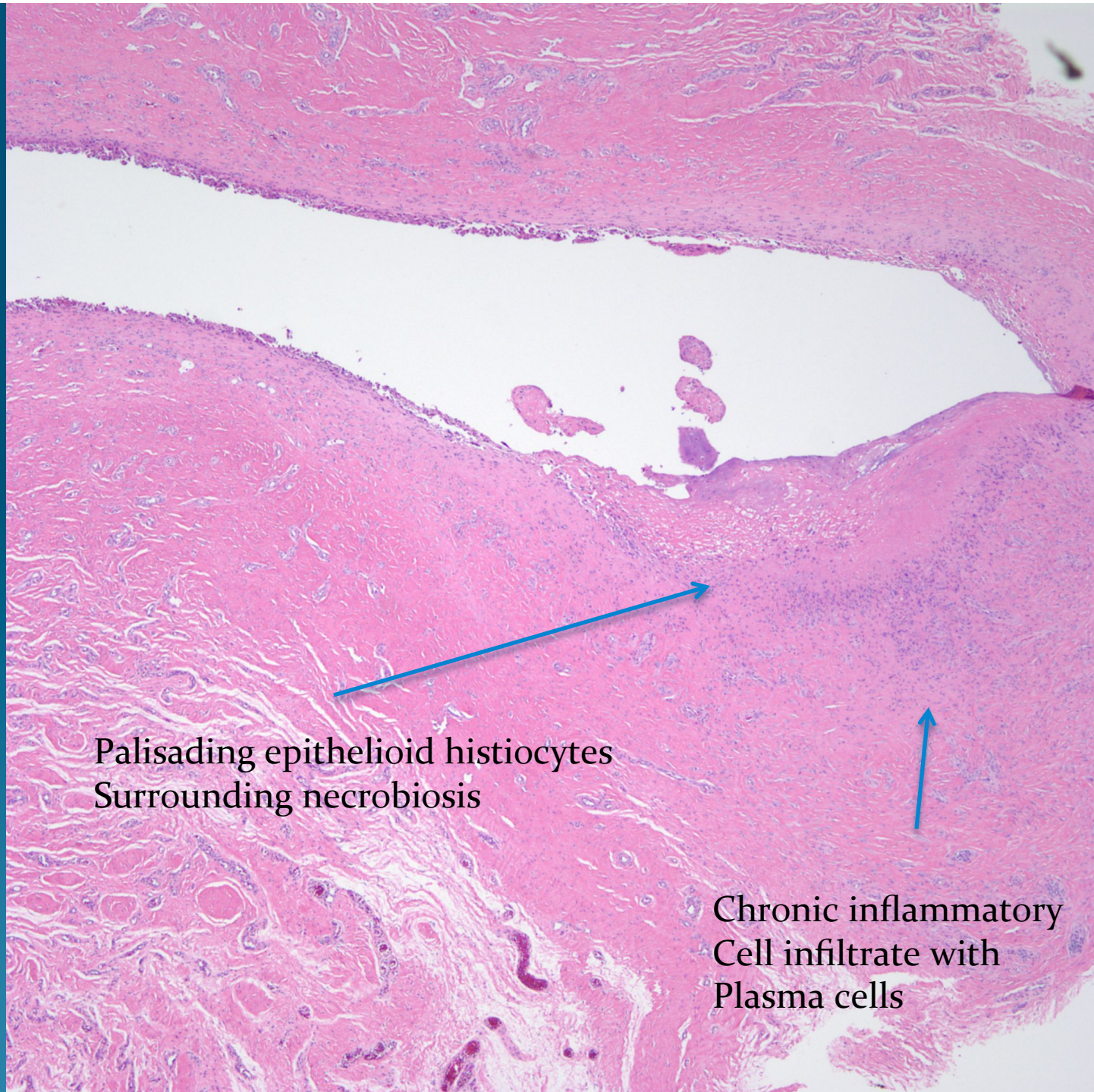
Pertinent differential diagnostic Considerations include all except:

- A. Foreign body reaction
- B. Sarcoidosis
- C. Cat scratch disease
- D. Rheumatoid nodule
- E. Tularemia

Sarcoidosis

Notes

- This is a palisading necrobiotic granuloma and is consistent with a rheumatoid nodule
- Sarcoidosis classically exhibits non-caseating granulomas with minimal surrounding inflammatory cells
- Histologically identical changes may be seen with a pseudo-rheumatoid nodule which is often times a response to a foreign body
- Zoonotic infections including Yersinia, Tularemia, and Cat-Scratch disease may also present with palisading necrobiotic granulomas
- In all cases, an infectious etiology should be excluded



Palisading epithelioid histiocytes
Surrounding necrobiosis

Chronic inflammatory
Cell infiltrate with
Plasma cells