

Dermoscopy of trichoblastic carcinoma

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Trichoblastic carcinoma is a rare malignant adnexal tumor deriving from the hair follicle. It is clinically highly similar to basal cell carcinoma (BCC), with a greater malignant potential and a higher metastatic risk [1,2]. Histopathology reveals lobules of small, basaloid cells, cytonuclear pleiomorphism, and numerous mitoses with follicular differentiation [1]. It is important to differentiate these two entities as they follow different clinical courses and, therefore, require different treatments [2]. To our knowledge, dermoscopy of this tumor has only been described once, showing scattered specks of brown pigment in a trichoblastic carcinoma of the scalp [3]. Herein, we present a dermoscopic description of a recurrent trichoblastic carcinoma.

A 93-year-old patient, who underwent an excision of a lesion of the left nasolabial fold two years previously with no record of histopathology, presented to our dermatology department with a lesion on the same site of excision evolving for the last six months. A clinical examination revealed a well-limited ulceration surrounded by a bluish, peripheric halo with an infiltrated base. Pigmented papules and telangiectasias were also observed along the scar of the nasolabial fold (Fig. 1). Dermoscopy showed blue, ovoid nests, brown and blue globules, telangiectasias, and a central ulceration (Fig. 2). A biopsy revealed a dermal tumor proliferation made from lobules and trabeculae of basaloid cells with nuclear atypia and numerous mitoses, which was more in favor of a trichoblastic carcinoma than a BCC. A radiological assessment revealed no regional or distant metastasis. The patient was referred to the plastic surgery department for further management.



Figure 1: Clinical picture of the ulcerated, bluish, pigmented plaque of the nasolabial fold.

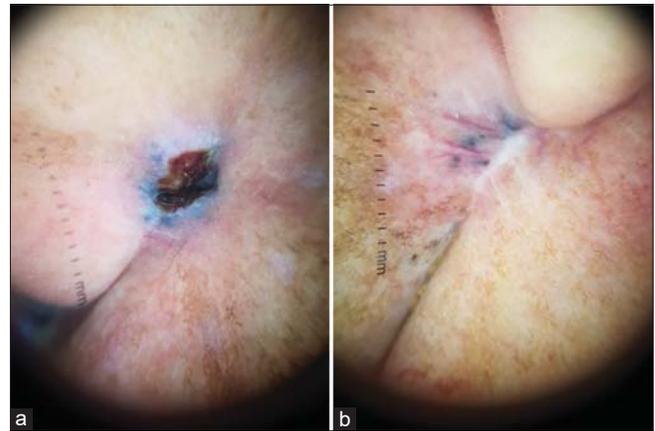


Figure 2: Dermoscopic picture of (a) a central ulceration with a bluish, peripheric halo; and (b) blue, ovoid nests, brown and blue globules, and telangiectasias along the underlying scar.

Consent

The examination of the patient was conducted according to the principles of the Declaration of Helsinki. The authors certify that they have obtained all appropriate patient consent forms, in which the

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patients gave their consent for images and other clinical information to be included in the journal. The patients understand that their names and initials will not be published and due effort will be made to conceal their identity, but that anonymity cannot be guaranteed.

REFERENCES

1. Romeu M, Foletti JM. Malignant cutaneous adnexal neoplasms of the face and scalp: Diagnostic and therapeutic update. *J Stomatol Oral Maxillofac Surg.* 2017;118:95-102.
2. Thomas M, Bruant-Rodier C. Why is it important to differentiate trichoblastic carcinomas (CT) from basal cell carcinomas (CBC): About 21 cases. *Ann Chir Plast Esthet.* 2017;62:212-8.
3. Kwok JT, Casady M. A trichogenic tumor with aggressive features initially diagnosed as basal cell carcinoma. *Dermatol Online J.* 2018;24:13030/qt1fn5226f.

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