Skin Tumors

Benign

Premalignant

&Malignant

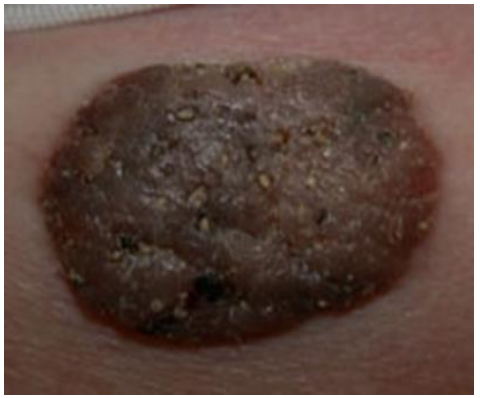
Benign skin tumors

Seborrhoeic keratoses

Seborrhoeic (seborrheic) keratoses are very common harmless skin tumer that appear during adult life.

Seborrhoeic keratoses may also be called basal cell papillomas, senile warts or brown warts.

Seen on both covered and uncovered parts of the body. There may be single or multiple.



Appears raised, stuck on appearance, brown-black well demarcated greasy scaly papules or plaques with warty surface.

The cause of seborrhoeic keratoses is unknown. The name is misleading, because they are not limited to a seborrhoeic distribution:(scalp, mid-face, chest, upper back) as in seborrhoeic dermatitis, nor are they formed from sebaceous glands as is the case with sebaceous hyperplasia.

They can follow sunburn or other irritating skin conditions.

Eruptive seborrhoeic keratoses(sudden 100 itchy lesions) may denote an underlying internal malignancy. The syndrome is known as the sign of Leser-Trelat

Treatment

Seborrhoeic keratoses can easily be removed by:

Cryotherapy

Curettage or/& cautery

Laser surgery

Shave biopsy

Skin tages (acrocordon)

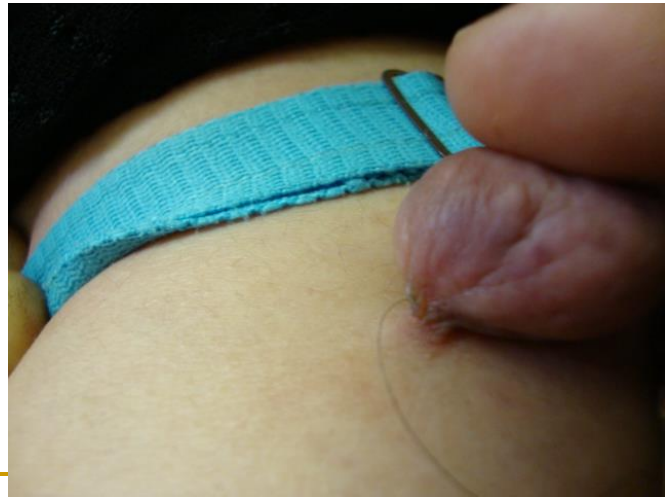
Common benign tumor

Seen in pregnant or obese patients

Site: axila, neck, inguinal area and eyelids.

Soft pigmented or skin colored pedunculated papules.

Treatment: scissor excision at the stalk.



Keloids & hypertrophic scars

A connective tissue response to trauma (laceration, cut, boil, acne, burn).

Pink or red growth, has consistency of rubber.

Lesion may be tender, painful or pruritic.

Hypertrophic scars: Lesion confine to the site of trauma, may regress with the time.

Keloids: Lesion extend beyond the site of trauma, it is not regress with the time.

Keloids & hypertrophic scars

Treatment

Hypertrophic scars generally settle with time but keloids resistant to treatment.

Dressings should be worn for 12 to 24 hours per day, for at least 8 to 12 weeks, and perhaps for much longer .

Moisturising oils

Silicone scar reduction patches

Pressure dressings

Surgical excision+ pressure dressing but may result in a second keloid even larger than the original one

Corticosteroid injection, repeated every few weeks

Cryotherapy

Superficial X-ray treatment soon after surgery .

Pulsed dye laser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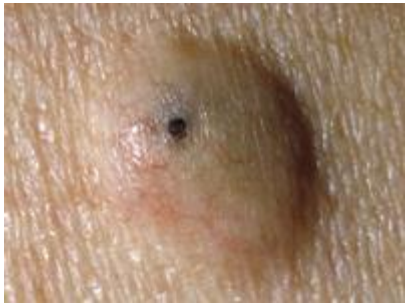
Epiderml or Pilar cyst (sebacous cyst)

The epidermal cyst is a moveable sac filled with a soft, whitish- brown material, that sometimes oozes out onto the skin's surface. This material, which is keratinous debris (dead skin cells), smells like rotten cheese.

Cysts can get inflamed if the contents of the cyst rupture into the surrounding skin. This makes them red and painful, and they may discharge yellow pus.

Treatment:

A small surgical excision. This is done under local anaesthesia. Occasionally the cyst recurs and needs further treatment.



Syringoma

Syringomas are harmless sweat duct tumours. They are most often found in clusters on the eyelids,

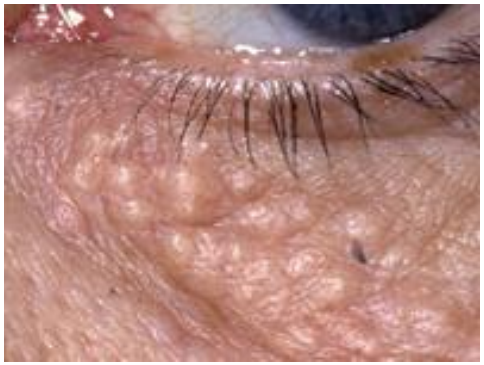
but they may also arise elsewhere on the face, in the armpits, umbilicus, upper chest and vulva.

A syringoma is a skin coloured or yellowish firm rounded papules, one to three millimetres in diameter.

They start to appear in adolescence and are more common in women than men. There is sometimes another affected member of the family.

Syringoma may be confused with xanthelasma (cholesterol deposits on the eyelids).

Treatment: Electrosurgery or lased destruction.



Melanocytic nevus (Mole)

I- Acquired Melanocytic nevus (Mole)

Melanocytic naevi (Moles) are common skin lesions.

They are due to a proliferation of the pigment cells= melanocytes.

They are brown or black in colour, they may also be called pigmented naevi.

Moles are benign in nature (harmless), but a malignant melanoma may arise within a mole.

Moles may be flat or protruding.

They vary in color from pink to dark brown or black.

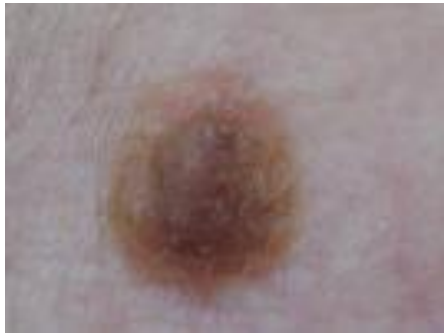
They range in size from a few millimeters to several centimeters in diameter.

The number of moles in a person has depends on genetic factors and on sun exposure;

Melanocytic nevus (Mole)

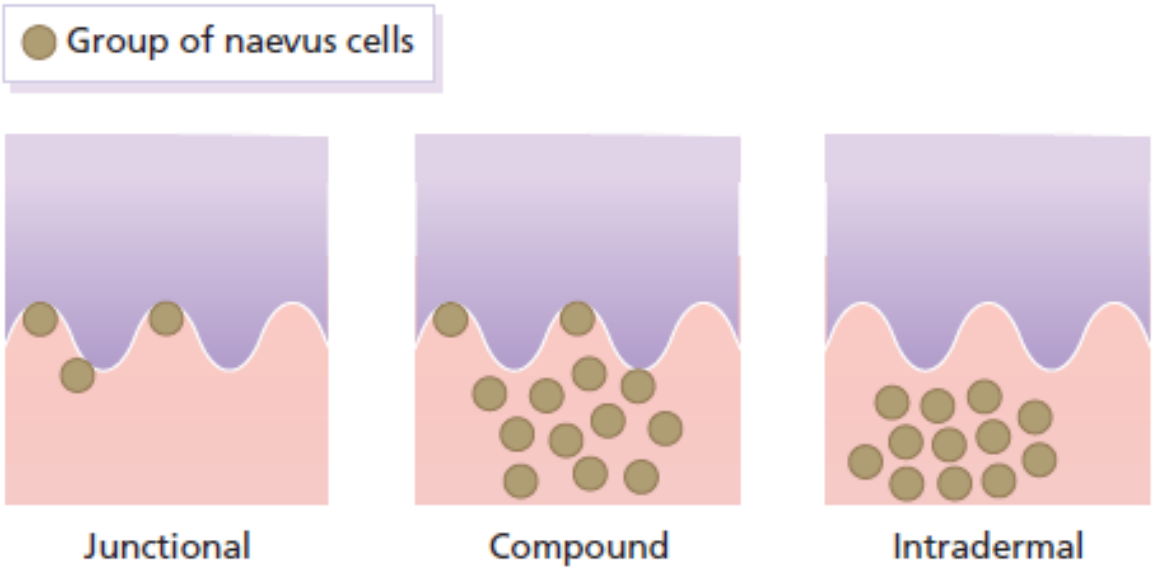
Classification of acquired Melanocytic nevus (Mole):
Nests level give the type

junctional



compound

intradermal



-Very very rare acquired nevi changes to malignant melanoma.

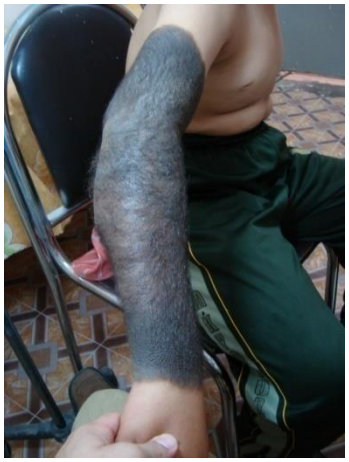
-Half of malignant melanoma occur in preexisting nevi.

-Signs of malignant degeneration:
irregular enlargement,
irregular border,
variegation in color(red, white, blue),
Surface changes(scaling, erosion, oozing, ulcer).

-Symptoms: pain, itching or tenderness

Melanocytic nevus (Mole)

II-Congenital melanocytic nevus: seen since birth. either small, middle or large



Pyogenic granuloma

An inflammatory reaction

Rapid growing lesion

Appears at the site of trauma

Red, friable nodule, bleed easily

Mainly seen in fingers.

Gums affected in pregnant female called epulis

Treatment: Curettage & cautery

Premalignant tumors

Keratoacanthoma(KA)

Rapidly growing squamous cell tumors do not invade and occasionally resolve spontaneously.

A keratoacanthoma looks like a little volcano. it may appear as a small pimple or boil

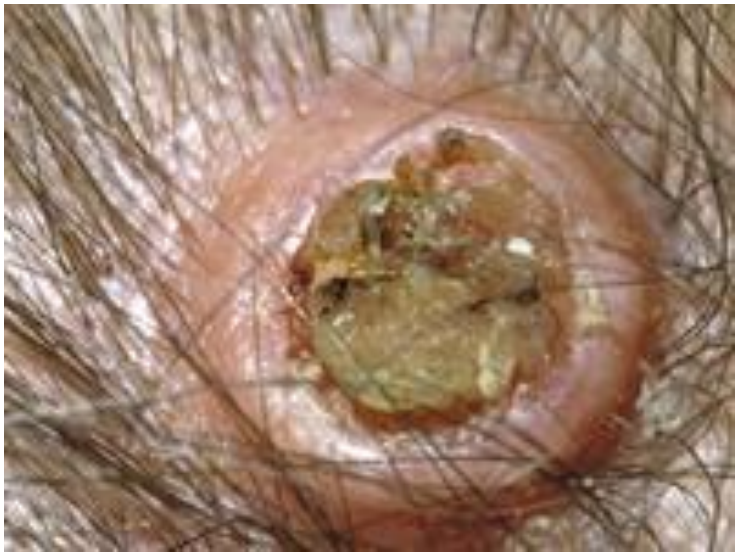
Rapid growing tumor, reach 2 cm in diameter within 2 months, pink color nodule with a crater filled with keratin

Keratoacanthoma(KA)

Untreated keratoacanthoma will grow for several months, reach a maximum size then self-destruct leaving scar.

Unfortunately a keratoacanthoma can look exactly like a true skin cancer, a squamous cell carcinoma (SCC), or less commonly like a basal cell carcinoma (BCC).

Treatment: curettage, freezing, excision



Solar Keratosis(Actinic keratosis)

Single or multiple, discrete, dry, rough(like coarse sandpaper), adherent scaly lesions occur on the habitually sun-exposed skin of adults.

Sex More common in males

Incidence Sun is an etiologic agent.

Race Skin phototypes I, II, and III, rare in IV, and almost never in blacks

Occupation Outdoor workers

Solar Keratosis(Actinic keratosis)

Lesion color Skin-colored, yellow-brown, or brown; often there is a reddish tinge

SIZE AND SHAPE Most commonly, 1cm, oval or round

DISTRIBUTION Isolated single lesion or scattered discrete lesions

SITES OF PREDILECTION Face (forehead, nose, cheeks, temples, vermilion border of lower lip), ears (in males), sides of the neck, forearms, and dorsal hands, shins

Prognosis:
1 squamous cell carcinoma developing yearly in each 1000 solar keratoses.

Treatment

- Cryotherapy
- Topical 5-FU flurouracil
- Topical imiquimod
- Topical diclofinac
- Curettage & cautery
- Excision
- Photodynamic therapy (PDT)
- Sunscreen

Oral Leukoplakia

A sharply defined, white, macular or slightly raised area that cannot be rubbed off and which remains after the irritation (e.g., tobacco smoking) has been stopped for several weeks. Affecting the tongue.

Candida infection may be a secondary invader.

Oral leukoplakia should be classified as a premalignant lesion because it is caused by exposure to the same agents that induce squamous cell carcinoma (SCC): smoking, alcohol, irritation from dentures or a sharp tooth.

Oral Leukoplakia

Age 40 to 70 years

Sex Males : females: 2 : 1

Etiology or Predisposing Factors Smoking (cigar, pipe, and cigarette), alcohol, and human papillomavirus (HPV-11 and HPV-16). Syphilis may be the etiology of leukoplakia of the tongue.

Red lesions (erythroplasia) or ulceration within the white plaques are a clinical indicators of dysplasia, so biopsy is indicated

Prognosis About 10 % of leukoplakia lesions can progress to malignancy

Treatment : Surgical excision, Cryotherapy

Oral Leukoplakia

Differential Diagnosis

Lichen planus,

oral lesion of chronic cutaneous lupus erythematosus,

oral hairy leukoplakia,

condyloma acuminatum,

bite “callus,” leukoderma,

nicotine stomatitis

Bowen disease(intraepidermal carcinoma)

- Slowly growing, sharply demarcated, pink, scaly plaque. Can change to scc (about 3% progress into an invasive squamous cell carcinoma).

DDX: psoriasis, discoid eczema, superfecial BCC)

(erythroplasia of queyrate): is bowen disease of the glans penis.

Treatment: Excision, cryotherapy

Malignant tumors

Basal cell carsinoma (BCC)

Basal cell carcinoma is also known as BCC, rodent ulcer.

Basal cell carcinoma is the most common type.

Arises from basal layer of the epidermis.

It is very rarely cause death.

BCC typically affects adults of fair skin had repeated episodes of sun exposure.

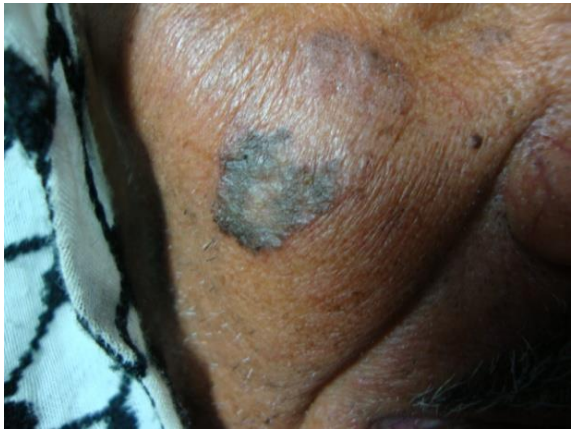
Pathogenesis

Early, intense sun exposure possibly causing p53 tumor suppressor gene mutations, allowing unrestricted proliferation

Clinical presentations:

Nodular BCC: Most common type on the face, Asymptomatic, small, shiny, skin colored or pinkish lump, blood vessels cross its surface with long history of disease reach to years.

Pigmented BCC: similar to the mole, may have a central ulcer so its edges appear rolled = rodent ulcer.



Superficial BCC: expand slowly on the trunk, reach to 10 cm

Treatment of BCC

1- Curettage &cautery

2- Excision

3- Cryotherapy

4- Imiquimod an immune response modifier

Squamous cell carcinoma of the skin

Squamous cell carcinoma (SCC) is a common type of skin cancer. It is derived from squamous cells, the flat cells that make up the outside layers of the epidermis.

These cells are keratinising i.e., they produce keratin, the horny protein that makes up skin, hair and nails.

Invasive SCC refers to cancer cells that have grown into the deeper layers of the skin, the dermis. Invasive SCC can metastasize (spread to distant tissues) and may prove fatal.

Invasive SCCs are usually slowly-growing, tender, scaly or crusted nodule. The lesions may develop sores or ulcers that fail to heal.

Most SCCs are found on sun-exposed sites, particularly the face, lips, ears, hands, forearms and lower legs.

The majority of invasive cutaneous SCCs are due to exposure to ultraviolet radiation, which damages the DNA of fair-skinned individuals.

SCCs most often arise within solar keratoses, and less often within Bowen's disease.

Other risk factors for invasive SSC include:

- Inherited predisposition to skin cancer. (xeroderma pigmentosa)
- Smoking– especially SCC of the lip.
- Thermal burn scars.
- Longstanding leg ulcers.
- Immunosuppression from drugs such as ciclosporin or azathioprine, especially in organ transplant recipients.
- Infection with human papillomavirus (HPV), the cause of viral warts, genital warts, and many mucosal SCCs..

Malignant Melanoma…types:

1- Acral lentiginous melanoma
2- superficial spreading Melanoma
3- Lentigo Maligna
4- Mucoasl Melanoma
5- Amelanotic Melanoma

Acral lentiginous melanoma

- Site: Foot, subungual, planter
- Browen or black nodule sometimes ulcerate
- Metastasis rapidly to local LN