H.K. Dermatol. Venereol. Bull. (2003) **11**, 77-79

Pearls in Dermatology

How I manage seborrhoeic keratosis

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Seborrhoeic keratosis classically presents as longstanding, minimally progressive, well demarcated pigmented keratotic papule or nodule with a 'stuck-on' appearance. Fine clinical features of multiple small keratin or milia-like cyst on granular or cerebriform surface are best seen at dermoscopy. Topical steroid-antibiotic mixture and trauma protection help to relieve the symptoms of irritated seborrhoeic keratosis. Simple curettage followed by electro-desiccation under local anaesthesia is best for treating large truncal lesions. For smaller truncal lesions, cryotherapy is the treatment of choice. Carbon dioxide and Q-switched Nd:YAG lasers as well as intense pulsed light are used for facial lesions. For eruptive lesions, oral acitretin can be used.

Keywords: Seborrhoeic keratosis

Introduction

Seborrhoeic keratosis (SK) is a common skin condition. In view of the increasing public awareness of cutaneous malignancy, particularly affecting the Caucasian population, the possibility of any pigmented lesion to be potentially carcinomatous is very much feared. Consequently, in general dermatological settings, one sees increasing number of patients presented with various benign lesions usually SK, seeking accurate diagnosis and exclusion of malignancy. Given the rarity for local Asian population to have cutaneous malignancy, particularly melanoma, the author's approach with patients presented with SK is very much accurate and confident diagnosis. After establishing the diagnosis, it is important to explain to the patient, in no uncertain terms, that the lesions are totally banal and there is no potential for carcinogenesis. The term 'senile keratosis' is best to be avoided, as patients universally dislike it. In the author's experience, SK occurs frequently in young adults starting in early twenties or even late teens! They are best referred to as maturity keratosis or spots.

Eruptive SK, particular among the elderly, has been reported to be associated with internal malignancy (Leser-Trelat sign). However, it is extremely rare and in the author's experience as a dermatologist for over twenty years, only

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one case was encountered in a London meeting. It is perhaps best to withhold this rare association from the patient, as it tends to generate unnecessary anxiety. Furthermore, accelerated and eruptive growth of SK is commonly seen in pregnant women, particularly affecting the sub-mammary areas. The growth phase usually continues until a few months post-partum and as a result, it is the author's policy not to treat them until the patient is three months post-delivery.

Diagnosis

Seborrhoeic keratosis lesions are frequently being partially 'scratched off', either accidentally or via a 'DIY' approach by patient to eliminate the lesion, confirming the superficiality of the lesion. In addition to the classical description of longstanding, minimally progressive, well demarcated pigmented keratotic papule or nodule with a 'stuck-on' appearance, the most useful signs that differentiate SK from melanocytic lesions is the presence of multiple small keratin or milia-like cyst on the surface of the lesion as well the granular or cerebriform surface. These fine features are best seen using a dermoscope, or at least using a magnifying glass.[1] The diagnostic accuracy is much enhanced using this technique.

Commonly, SK particularly over areas of friction becomes irritated and there may be signs of inflammation or even bleeding. Sometimes, there may even be minor abrasions or erosions and the patient may complain of pruritus or pain. Application of a steroid antibiotic mixture, such as 2% fusidic acid with 0.1% betamethasone valerate cream, and covering the inflamed lesion with band-aid to reduce further friction, often helps after five to seven days. Digital photographic documentation is advised as it allows comparison at reassessment.

Treatment

Indications for treatment would include cosmetic or nuisance reasons and occasionally patients would request removal for geomancy reason! For large SK lesions on the trunk, at least 3 to 4 mm in height and 1.5 cm in diameter, simple curettage followed by electro-desiccation (Bircher Hyfrecator) under local anaesthesia is simple and gives excellent cosmetic result. However, sun-protection must be advised during recovery to minimize the risk of post-inflammatory hyperpigmentation. For smaller lesions, particularly on the trunk, cryosurgery is the treatment of choice. The author uses the standard Brymill Cryac spray, aperture B or C, adopting a single freeze/thaw cycle of about ten to twenty seconds, depending on the size. Response to cryosurgery is quite variable and freezing time needs to be adjusted after test area.

For smaller SK including stucco and dermatosis papulosa nigra lesions, particularly on the face, the author prefers carbon dioxide laser (Luxar). The parameter that is usually used is 20 ms pulse width and fluence between three to ten joules/cm^2. The desiccated debris can be rubbed off with saline soaped Q-tips or a small curette (Figure 1). Flat SK can also be treated with other types of laser, particularly those on the face or patients with a high risk of post-inflammatory hyperpigmentation. The author favours the Q-switched Nd:YAG laser, particularly using the 532 nm wavelength. The usual parameter used is 3 mm spot size between one to two joules/cm^2 energy density achieving the usual end point of immediate whitening. More recently, the author also finds intense pulsed light (Ellipse DDD) effective in treating flat SK at 2.5 ms, eight to nine joules/cm^2.

Rarely for individuals with eruptive SK who are very bothered by the lesions, oral retinoid is very useful to halt the progression and

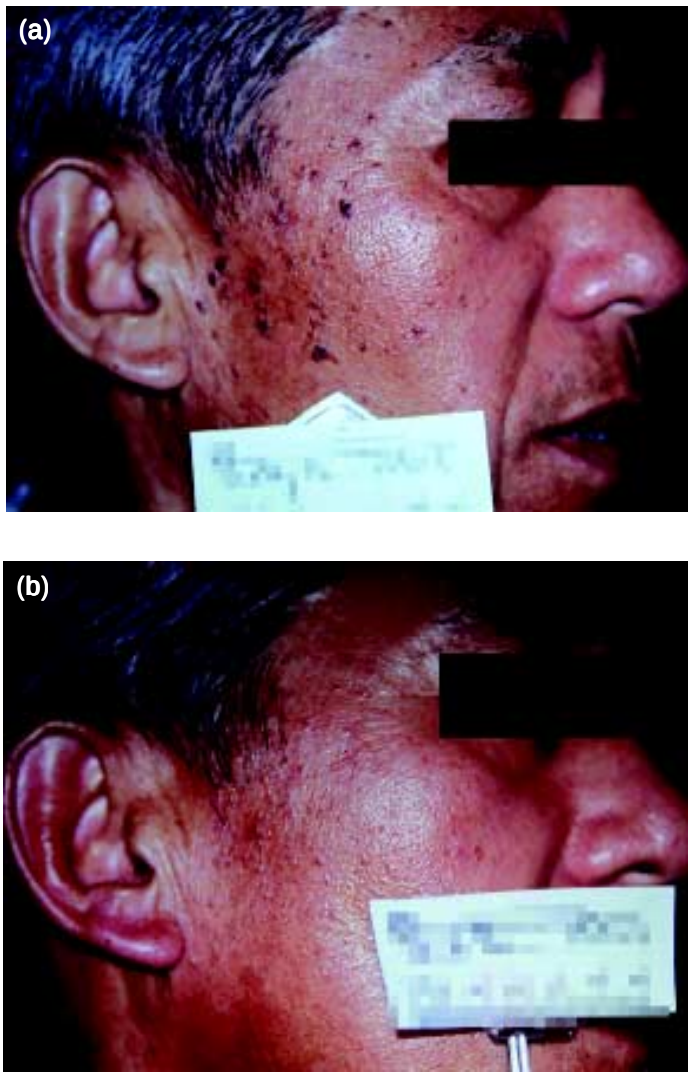

Figure 1. CO_2 laser ablation of multiple small facial seborrhoeic keratoses: (a) preoperative view; (b) after complete removal.

sometimes even promote resolution. After all the pre-requisite counselling and blood tests, a dose of acitretin at 0.5 mg per kilogram per day for three to four months is usually very helpful.

Reference

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