Locally Aggressive Trichoblastoma or Basal Cell Carcinoma? What is the Benefit of Dermoscopy? A Case Report

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Abstract

Trichoblastoma is a predominantly dermal benign hair follicle tumor, characterized by well-circumscribed nests and cords of bland follicular basaloid cells in close association with stroma. The aggressive form is rare and its diagnosis remains difficult, because of its similarities with basal cell carcinoma. We report a case of an 80 years old male patient and discuss the morphological differences between the two tumors.

Keywords

Locally Aggressive Trichoblastoma; Basal Cell Carcinoma; Difference; Dermoscopy

Introduction

Trichoblastoma is a benign adnexal tumor that derives from the germinating follicular cells of the pilosebaceous follicle. The aggressive form is rare, and hence needs distinction from the basal cell carcinoma [1]. We report a case of aggressive trichoblastoma.

Observation

An 80 years old patient, with a history of chronic sun exposure, who presented, 20 years before admission, an erythematous lesion of 3 cm on the left naso-labial fold, which increased in size becoming ulcerated after a micro trauma. The clinical examination objected an ulcerated plaque of 3 cm with irregular contours, surmounted by haemorrhagic crusts with a slightly infiltrated base (Fig. 1). Clinically a provisional diagnosis of basal cell carcinoma was made. Dermoscopy revealed a central ulceration surrounded by yellowish-brown background, in which shiny white blotches and strands over the entire lesion border, rosette-like appearance, milia like appearance, grayish pigmented areas locally located and fine telangiectasias are noted (Fig. 2). Ganglion areas are free. Histology shows atrophic epidermis. Dermis showed tumor cells arranged in islands and massive cribriform tumors with focal epidermal connection. Those islands were surrounded by fibroblastic stroma, who was very inflammatory with plasma cells and few lymphocytes. The stroma, more in contact with tumour structures, is made of elongated fibroblasts lace like at places into invaginations within these structures. Focally retraction artifact was noted between the tumour nodules and the surrounding interstitium (Fig. 3). Hence a final diagnosis of trichoblastoma was made. Treatment was surgical with healthy margins (3 mm at the nearest limit), with no local or distant recurrence at following of the patient of 1 years after tumors excision.

Figure 1: An ulcerated plaque of 3 cm with irregular contours, surmounted by hemorrhagic crusts with a slightly infiltrated base.

Figure 2: Central ulceration surrounded by yellowish-brown background, in which shiny white blotches and strands (white narrows) over the entire lesion border, rosette-like appearance (white stars), milium like appearance (yellow stars), grayish pigmented areas (black narrows) and fine scarcely branching telangiectasies (red narrows).

Figure 3: Atrophic epidermis + tumor cells arranged in islands and massif cribriform tumors + fibroblastic inflammatory stroma + fibroblasts lace like at places into invaginations.

Discussion

Locally aggressive trichoblastoma, also known as "low-grade trichoblastic carcinoma", "trichoblastic fibroma", or "exceptionally aggressive trichoblastoma" is a tumour that develops from immature germ hair cells without atypia. It has long been confused with nodular basal cell carcinoma, which has clinical, dermoscopic and histopathological similarities [2]. Multiple cases of trichoblastoma invading the hypodermis and skeletal muscle have been reported. In where, male dominance was noted, and the most frequent topography was the face [3]. Dermoscopy may show white bloches, milia cysts and white striae, grayish-blue or brown dots and scarcely arborizing vessels, all on a yellowish-brown or pearly background [4]. A presence of blue-ovoid nests is more frequently related to basal cell carcinoma, but the most striking dermoscopic differenced element is the presence of blue-grey globules and blotches shiny areas with scarcely branching telangiectasis, that were found to be significantly more frequent but not exclusive of trichoblastoma [5,6]. The detection of these dermoscopic features may help the clinician to orient the differential diagnosis. However, the histological examination is the key of diagnosis [7].

Conclusion

Locally aggressive trichoblastoma is a rare skin tumor, which has clinical, dermoscopic and histological similarity with basal cell carcinoma. Dermoscopic features may help the clinician to orient diagnosis. But a good collaboration is important for both clinicians and pathologists to resolve the enigma of this diagnosis.

Reference

1. Midassi O, Hammami H, Koubaa W. Les trichoblastomes: étude anatomoclinique et dermoscopique. In Annales de Dermatologie et de Vénéréologie. 2017;144(12):S170.
2. Hua C, Cribier B, Osio A, Janin A, Battistella M. Trichoblastomes localement agressifs: étude clinico-pathologique et pronostic à long terme. In Annales de Dermatologie et de Vénéréologie 2014;141(12):S243.
3. Hua C, Velter C, Osio A, Lebbé C, Basset-Seguin N, Cribier B, et al. Locally aggressive trichoblastic tumours (low-grade trichoblastic carcinomas): Clinicopathological analysis and follow-up. Acta Derm Venereol. 2018;98(2):126-7.
4. Pitarch G, Botella-Estrada R. Dermatoscopia del trichoblastoma. Actas Dermo-Sifiliograficas. 2015;106(9):e45-8.
5. Amita K, Shankar VS, Sarvesh BM, Abhishek MG. Trichoblastoma or basal cell carcinoma: A Case Report with literature review highlighting the differences. Ind J Pathol. 2015;4(2):81.
6. Huet P, Barnéon G, Cribier B. Trichoblastome: corrélation dermatopathologie-dermoscopie. In Annales de Dermatologie et de Vénéréologie. 2017;144(6-7):462-5.
7. Ghigliotti G, De Col E, Parodi A, Bombonato C, Argenziano G. Trichoblastoma: is a clinical or dermoscopic diagnosis possible? J Euro Acad Dermatol Venereol. 2016;30(11):1978-80.