Solitary trichoepithelioma in an 8-year old child: clinical, dermoscopic and histopathologic findings

Elizabeth Lazaridou¹, Christina Fotiadou¹, Aikaterini Patsatsi², Anastasia Fotiadu³, Eirini Kyrmanidou¹, Christina Kemanetzi¹, Demetrios Ionnides¹

1 First Department of Dermatology/Venereology, Aristotle University Medical School, Thessaloniki, Greece
2 Second Department of Dermatology/Venereology, Aristotle University Medical School, Thessaloniki, Greece
3 Laboratory of Diagnostic Histopathology, Thessaloniki, Greece

Key words: trichoepithelioma, basal cell carcinoma, diagnosis, dermoscopy, histopathology


Received: July 9, 2013; Accepted: December 26, 2013; Published: April 30, 2014

Copyright: ©2014 Fotiadou et al. This is an open-access article distributed under the terms of the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original author and source are credited.

Funding: None.

Competing interests: The authors have no conflicts of interest to disclose.

All authors have contributed significantly to this publication.

Corresponding author: Christina Fotiadou, First Department of Dermatology/Venereology, Aristotle University Medical School, Delfon 124 St, 54643, Thessaloniki, Greece. Tel. +3069 7728 0280 Email: cifotiadou@hotmail.com

ABSTRACT

Solitary trichoepithelioma (TE) is a rare, benign tumor of follicular origin that in certain cases is difficult to differentiate from basal cell carcinoma (BCC). We report the case of an 8-year-old girl with a pale pink, soft lesion on the neck. The clinical image of the lesion was equivocal, while some dermoscopic findings—blue-gray globules and arborizing vessels—could not exclude the presence of BCC from the differential diagnosis, although that would have been a very unlikely case considering the age of the patient. The histopathologic examination established the diagnosis of TE. Given the occasion of this challenging case we try to list the key clinical, dermoscopic and histopathological characteristics of TE and BCC in order to elucidate the differential diagnosis of these two entities.

Case presentation

We report the case of an 8-year-old girl who was referred to our pigmented lesions clinic exhibiting a pale pink lesion (almost 1 cm in diameter) with a soft, lobulated surface (Figure 1). This lesion had been present on the neck of the child for a year but during the previous six months had enlarged. The personal and family history of the patient was negative for the presence of other similar lesions. The dermoscopic examination, performed at that time with a handheld dermatoscope (Dermlite II HR PRO by 3GEN), revealed a translucent white background with blue-gray globules at the periphery and very subtle arborizing vessels (Figure 2). These features could not exclude the possibility of basal cell carcinoma (BCC) although that would have been a very unlikely diagnosis in an 8-year-old child. The lesion was surgically excised. The histopathologic examination undoubtedly established the diagnosis of trichoepithelioma (TE) and was characterized by the following findings: lobules of basaloid cells were arranged within the lamina propria, with no connection to the epidermis (Figure 3). At the periphery of the lobules, the neoplastic cells displayed characteristic palisad-
TE is a rare, benign dermal tumor of follicular origin [1]. Three major variants have been described in the literature, namely solitary, multiple and desmoplastic TE [1]. The solitary subtype is commonly found in young adults. It is usually located on the central face and on the perinasal area in particular. This site predilection could be attributed to the high concentration of pilosebaceous units in this area. However, on rare occasions TE can acquire a diameter of ≥1 cm and can be situated on the neck, scalp or trunk [2]. Sometimes, TE can closely resemble BCC. The occurrence of TE and/or BCC in childhood, although it has been reported in anecdotal cases, is very uncommon [3]. The key clinical, dermoscopic and histopathologic characteristics of TE and BCC are summarized in Table 1.

**Discussion**

**Figure 1.** Clinical image of the lesion. [Copyright: ©2014 Fotiadou et al.]

**Figure 2.** Dermoscopic image of the lesion showing blue-gray dots at the periphery (black arrows), subtle arborizing vessels (white arrows) and white-translucent background (DermLite II HR PRO by 3GEN). [Copyright: ©2014 Fotiadou et al.]

**Figure 3.** Histopathologic image of the lesion (hematoxylin & eosin X20) showing lobules of basaloid cells not connected to the epidermis. [Copyright: ©2014 Fotiadou et al.]

**Figure 4.** Small keratin cysts and peripheral palisading are characteristic features of the tumor cell lobules (H&E X400). [Copyright: ©2014 Fotiadou et al.]

**Figure 5.** A conspicuous perilobular connective tissue sheath is present focally (H&E X100). [Copyright: ©2014 Fotiadou et al.]


In this case the clinical presentation of the lesion was in favor of TE mainly due to its soft surface and to the absence of central erosion or ulceration, which usually develops in enlarging BCCs. Moreover, the young age of the patient almost excludes the diagnosis of BCC, although the relatively rapid enlargement of the lesion (6 months to 1 year) is not characteristic for TE. The dermatoscopic examination revealed several findings that could be attributed to BCC, such as some blue-gray globules and fine arborizing vessels. However these vessels, in contrast to the arborizing vessels commonly found in a nodular BCC, were very thin, few in number and were not “in focus” under dermatoscopy. The presence of blue-gray globules, which were not very evident to the clinical eye, probably corresponds on histopathology to presence of melanin within the neoplastic aggregates found in the dermis. All the above criteria taken together with the absence of other well-known dermatoscopic clues for the diagnosis of BCC, such as leaf-like structures and spoke-wheel areas, do not coincide with the typical findings in BCC. Finally, the histopathologic examination undoubtedy proved the diagnosis of TE by revealing the following characteristics: abundance of stroma relative to the neoplastic aggregates, lack of connection between the tumor lobules and the surface epithelium, presence of keratinous cysts, and finally absence of ulceration and mitoses.

In conclusion, histopathology remains the gold standard method for the differential diagnosis between TE and BCC. The dermatoscopic criteria for TE need further investigation since only a small case series has been published until now. Moreover, dermatoscopic findings must always be interpreted in light of important clinical information, such as the age of the patient and the natural history of the lesion. In that sense, our case shows that dermatoscopic criteria suggestive of the diagnosis of BCC, such as blue-gray globules and fine arborizing vessels, can also be seen in some cases of TE.

**References**