

Hyperkeratosis of the Nipple as a Neglected Dermatosi

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Introduction

We read with interest the article by Kaminska-Winciorek et al [1] describing neglected nipples with acanthosis nigricans-like appearance. We present another case of this condition and briefly review the differential diagnosis.

Case Presentation

The patient was a 43-year-old man with a history of chronic renal disease who had undergone a second kidney transplant 3 months previously and was receiving tacrolimus, mycophenolate mofetil, and prednisone. He was referred to the dermatology department because of a slowly growing pigmented lesion on his left nipple, which appeared after the second transplant. The lesion was asymptomatic, with no history of bleeding. Examination revealed a brown, warty, keratotic, 3- × 1-cm plaque on the upper portion of the left areola (Figure 1A).

At dermoscopy, no pigment network, atypical vessels, or any other signs of malignancy were observed. It showed polygonal and angulated clods with a keratotic, shiny black-

ish surface (Figure 1B). A broad differential diagnosis was made, given the presence of a pigmented lesion on an organ-transplant recipient with immunosuppressive therapy. However, dermoscopy was an essential and reassuring examination, allowing a presumptive diagnosis of hyperkeratosis of the areola.

Interestingly, the patient was very concerned and uncomfortable during examination; he experienced extreme sensitivity of the left nipple, referring discomfort and unbearable tickling in reaction to touching and laying the dermatoscope on this area. When asked, he admitted the possibility of poor hygiene in that area due to this condition. After 2 hours of occlusive anesthetic cream, the lesion was smoothed and easily removed using a 4-mm curette (Figure 1, C and D, and Figure 2), with no pain or bleeding.

Conclusions

Hyperkeratosis of the nipple and areola (HNA) is an uncommon and benign condition first described in 1923 by Tauber. Since then, a few attempts to classify this entity have been unsuccessful and it remains controversial whether HNA is a



Figure 1. Clinical and dermoscopic overview of the lesion before (A, B) and after (C, D) curette removal. Brown, warty, keratotic plaque on upper portion of left areola (A), showing polygonal and angulated clods with a keratotic, shiny blackish surface on dermoscopy (B). [Copyright: ©2019 Jimenez-Cauhe et al.]

distinct entity or a clinical presentation of other dermatoses [2]. In practice, it is a morphological diagnosis that depicts a unilateral or bilateral brown keratotic plaque on the nipple and/or areola. The idiopathic type is usually known as nevoid hyperkeratosis of the nipple and is more common in women after puberty. However, this entity is questioned and most authors point out that hyperkeratosis results from other dermatoses. Differential diagnosis includes acanthosis nigricans, seborrheic keratosis, and epidermal nevus and, rarely, malignant tumors such as pigmented squamous cell carcinoma, Paget disease, and melanoma may mimic this condition. Some cases have been associated with endocrinopathies or estrogen hormonal treatment [2] and, recently, with BRAF inhibitor therapy [3].

Nevertheless, HNA resulting from avoidance of cleansing is not reported on previous cases and probably underestimated. Only 2 cases of acanthosis nigricans-like plaques on both nipples due to neglecting hygiene have been reported by Kaminska-Winciorek et al. This hyperkeratotic brownish appearance, similar to other terra firma-forme dermatosis, is caused by retention of keratinocyte debris [1].

In conclusion, increased skin sensitivity in certain body areas might be an important clue in the anamnesis of this kind of lesion. When present, neglected dermatosis should be in the differential diagnosis of hyperkeratosis of the nipple-areola complex.

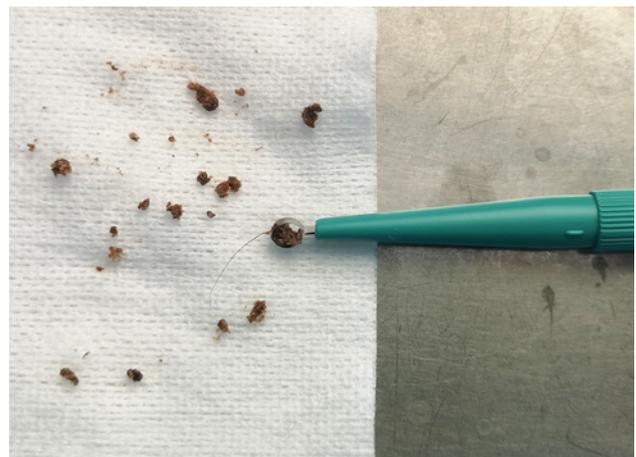


Figure 2. Keratotic material removed using a 4-mm curette. [Copyright: ©2019 Jimenez-Cauhe et al.]

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