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FNA Of Seborrheic Keratosis: A Case Report

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Abstract

Seborrheic keratosis (SK) is a common benign epidermal tumor, often diagnosed clinically. However, in certain cases, fine needle aspiration (FNA) cytology can be utilized to confirm the diagnosis, especially when the lesion presents atypical features. This study aims to evaluate the cytological features of SK using FNA and to assess its diagnostic accuracy.

Key words: SK(Seborrheic keratosis), FNA(Fine needle aspiration)

Introduction

Seborrheic keratosis (SK) is a benign intraepidermal neoplasm originating from epidermal keratinocytes.[1] Commonly referred to as senile warts, these lesions frequently appear on aging skin, particularly on the trunk, head, neck, and within skin folds. The diagnosis of seborrheic keratosis is straightforward in most cases, as these lesions are extremely common in the elderly.[1] However, due to their high variability in clinical and dermoscopic presentation, they can sometimes be misdiagnosed, mimicking conditions such as melanoma, squamous cell carcinoma, and basal cell carcinoma.[2]

Case report

A 48-year-old female presented to us with painless slow growing nodular brown-black colored swelling on the scalp measuring 1.5cm in diameter. Overlying skin was fixed to the swelling. No ulceration was seen and swelling was not fixed to deeper structures.

Diagnostic Assessment

FNA was performed using a 20 ml syringe. Needling was done using a 23-gauge needle. Aspirate obtained was stained with Giemsa and PAP stain and then examined under the microscope. Cytological examination revealed scant cellular smears showing few basaloid cells and sweat glands. A diagnosis of benign adnexal neoplasm was offered on cytology. Patient then underwent excision biopsy. Histopathological examination revealed a well circumscribed lesion showing sheets of basaloid cells and horn cysts filled with keratin. Based on these features a diagnosis of seborrheic keratosis was offered.

Figure 1 Clinical photograph: A nodular pigmented lesion noted in the scalp

Figure 2 PAP stain 400X: Basaloid cells and sweat glands are seen

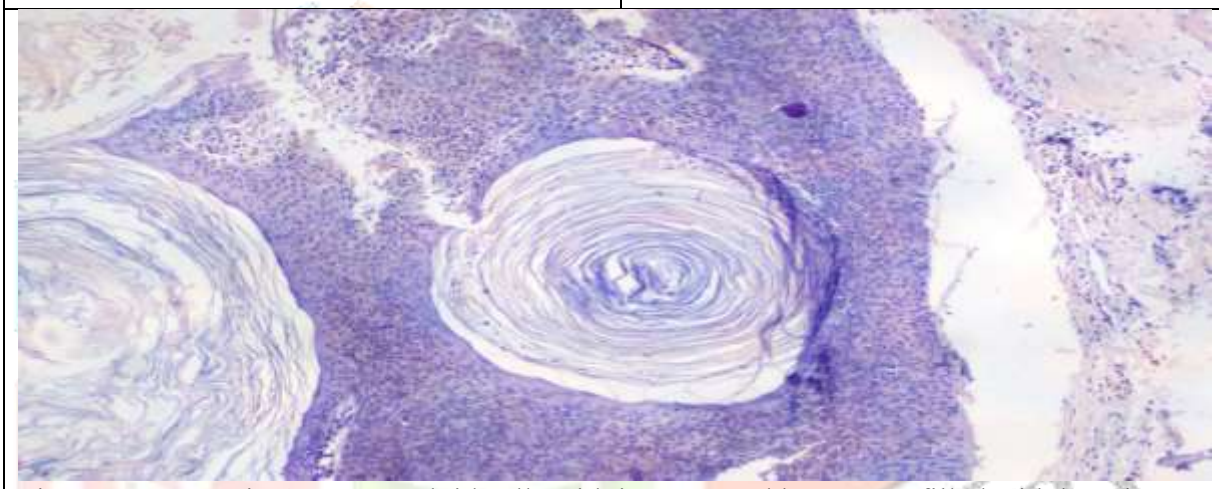

Figure 3 H&E stain 400X: Basaloid cells with interspersed horn cysts filled with keratin

Discussion

Seborrheic keratosis (SK) is one of the most common benign skin tumors, particularly prevalent among older adults. Despite its benign nature, understanding its clinical presentation, histopathological features, and differential diagnosis is crucial for accurate identification and management. Seborrheic keratosis typically presents as sharply defined and often have a “stuck-on” appearance. Lesions can range from light tan to black. They may be smooth, waxy, or verrucous (wart-like) and are commonly found on the trunk, face, and extremities. Patients often seek medical advice due to cosmetic concerns or because the lesions can sometimes be mistaken for malignant skin conditions. Due to scant aspirate in our case, a definite diagnosis could not be ascertained on FNA. Histopathological analysis confirmed the diagnosis of seborrheic keratosis based on typical features.

Conclusion

Fine needle aspiration (FNA) of seborrheic keratosis can provide valuable cytological information, typically revealing benign squamous cells with features such as hyperkeratosis, acanthosis, and papillomatosis.[3] However, the utility of FNA in diagnosing seborrheic keratosis is limited due to the superficial nature of the lesion and the potential for sampling error. Histopathological examination remains the gold standard for definitive diagnosis, as it allows for a more comprehensive assessment of the lesion's architecture and cellular details.[4,5] Therefore, while FNA can support the clinical diagnosis of seborrheic keratosis, it should be complemented by histopathological evaluation to ensure accuracy.

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